



NC DEPARTMENT OF  
**HEALTH AND  
HUMAN SERVICES**  
Division of Public Health

**Request for Applications**

RFA #A-412

***Improving Community Outcomes for Maternal and Child Health  
(ICO4MCH)***

**FUNDING AGENCY:** North Carolina Department of Health and Human Services  
Division of Public Health  
Women, Infant, and Community Wellness Section  
Infant and Community Health Branch

**ISSUE DATE:** October 25, 2023

**DEADLINE DATE:** December 20, 2023

**INQUIRIES and DELIVERY INFORMATION:**

Direct all inquiries concerning this RFA to:

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Program Manager

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336-894-0877 Cell

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**Applications will be received until 5:00pm on December 20, 2023.**

Electronic copies of the application are available at <https://wicws.dph.ncdhhs.gov/>.

Send all applications electronically to the address indicated below:

[Ladonna.warren@dhhs.nc.gov](mailto:Ladonna.warren@dhhs.nc.gov)

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## **INTRODUCTION**

The North Carolina Division of Public Health-Women, Infant, and Community Wellness Section (DPH/WICWS) develops and promotes programs and services that protect the health and wellbeing of infants and women during their childbearing years. The goals are to improve the overall health of women, reduce infant sickness and death, and strengthen families and communities. The Improving Community Outcomes for Maternal and Child Health (ICO4MCH) Program was established in 2015 to provide funding to local health departments (LHDs) to improve birth outcomes, reduce infant mortality, and improve health among children ages birth to five. Grants will be awarded for a two-year period and will be administered by the Division of Public Health-Women, Infant, and Community Wellness Section-Infant and Community Health Branch.

The health of individuals of reproductive age (14-44 years) and children ages 0-5 is critical to the health of communities. ICO4MCH program efforts will focus on several key indicators which provide information on the health of women and young children including:

### **Infant Mortality**

In 2021, the infant mortality rate in North Carolina (NC) returned to a historic low of 6.8 infant deaths per 1,000 live births, accounting for 820 infants who died before reaching their first birthday. The national infant mortality rate was 5.4 per 1,000 live births in 2021. Significant variance in rates among racial/ethnic groups continues to exist in NC. The combined 2019-2021 Non-Hispanic (NH) Black infant mortality rate was 12.7 per 1,000 live births while the NH White rate was 4.8, with the infant mortality rate disparity ratio equal to 2.6. The rate of NH American Indian and Hispanic infant deaths was 8.7 and 5.5 per 1,000 live births, respectively. Thirty-five counties had a disparity ratio higher than the state ratio.

### **Child Poverty**

The percent of children under five years of age living in poverty in NC decreased from 26.4% in 2015 to 20.2% in 2021, according to the U.S. Census Small Area Income and Poverty Estimates. NC continues to have higher rates of poverty than the national rate, which decreased from 22.8% in 2015 to 18.3% in 2021. NC ranked fourteenth highest among all states for poverty rates of children under five years of age. County-level data estimates for the percent of children under the age of five are available from the US Census Bureau 2017-2021 American Community Survey (ACS). While the state estimate from this survey period is 21.3%, the estimated poverty levels ranged from 7.6% to 57.8% among NC counties.

### **Child Health Insurance**

According to U.S. Census Small Area Health Insurance Estimates (SAHIE), 94.5% of children under the age of 19 in NC had health insurance in 2021, an increase from 92.1% in 2011. However, disparities exist among racial/ethnic groups. Per 2017-2021 American Community Survey (ACS) data, 92.3% of American Indian and 88.1% of Hispanic children had health insurance compared to 95.7% of African American, 95.1% of Asian, and 95.9% of NH white

children. According to 2017-2021 ACS data, 41.1% of all children under the age of 19 in NC are covered by public health insurance.

## **ELIGIBILITY**

Only local health departments/districts are eligible to apply for this RFA. Given the amount of funding available, the awarding of funds will be competitive. Single, regional, or multi-county applications are encouraged. For a multi-county application that includes different local health departments, one county must take the lead in submitting the application. DPH will accept applications from single or multi-county local health departments (LHDs) that meet certain criteria of need.

The criteria are:

1,000 or more births in 2021 in the county(ies)

## **AND**

1. At least **ONE** of the following:

- Combined 2019-2021 infant mortality rate must be 10.2 or higher per 1,000 live births and 20 or more infant deaths
- Combined 2019-2021 infant mortality disparity ratio must be 2.6 or higher
- Percent of children <5 years of age living in poverty must be 32% or higher (ACS 2017-2021 data) or
- Percent of children <19 years of age who are uninsured must be 8.3% or higher (2020 SAHIE)

LHDs should determine their eligibility, either as a single county or multi-county project, by assessing the data above using the tool provided by DPH in September 2023. The eligibility tool can be found online: <https://wicws.dph.ncdhhs.gov>.

## **FUNDING**

Up to five (5) ICO4MCH projects will be funded at an award level of \$350,000-\$450,000 annually. Funds will be awarded for a two-year period, contingent upon contract compliance, program performance, and the availability of funding. The project period for agreement addendums awarded through this competitive application process will begin June 1, 2024, and end May 31, 2026.

## **I. BACKGROUND**

Session Law 2023-59, Section 9H.1.(a) continues funding to the DPH to implement evidence-based strategies (EBS) that are proven to lower infant mortality rates, improve birth outcomes, and improve the overall health status of children ages birth to five. This session law requires the establishment of a competitive process to award grants to local health departments to implement evidenced-based strategies to achieve these aims. The law places the following requirements on the DPH when selecting local health departments to be funded:

- the Division shall prioritize grant awards to local health departments that are able to leverage non-State funds in addition to the grant award,
- the grant awards to local health departments who are dedicated to providing services on a county-wide basis,
- local health departments shall participate in evaluation, including measurable impact or outcomes, and
- each ICO4MCH local health department site ensures that funds received to implement the plan will supplement and not supplant existing funds for health and wellness programs and initiatives.

## II. SCOPE OF SERVICES

The ICO4MCH Program aims are to improve birth outcomes, reduce infant mortality, and improve the health status of children, ages 0 – 5. The table below outlines each program aim and the evidence-based programs that can assist LHDs to achieve each program aim. **Each Applicant must address all 3 program aims. Each Applicant must select one of the evidence-based/evidence-informed strategies for each aim.**

PROGRAM AIMS	EVIDENCE-BASED STRATEGIES
<b>A. Improved Birth Outcomes</b>	Reproductive Life Planning (RLP)
	Improving Preconception and Interconception Health
	Doula Services
<b>B. Reduced Infant Mortality</b>	10 Successful Steps for Breastfeeding, with a specific focus on Step 3 and Step 10
	Tobacco Cessation and Prevention
<b>C. Improved Health Status of Children Ages 0-5</b>	Positive Parenting Program (Triple P)
	Family Connects Newborn Home Visiting

**Appendix A** contains detailed program descriptions of each evidence-based strategy. This includes scope of services, performance measures, and reporting requirements.

To address the program aims listed above, each funded site should implement the project using the required and optional components described below. Each funded site is required to use the Collective Impact framework and address health inequities that result from health disparities in each of their selected evidence-based strategies. In at least one of the selected evidence-based strategies, **the funded site is required to incorporate a Community Health Worker model.**

### COLLECTIVE IMPACT

The complexity and challenges facing communities to improve the health of individuals of reproductive age and children ages 0-5 can be overwhelming. Collaboration between community-based organizations, local health departments, and other key stakeholders can lead to long-term systematic change. Collective impact is an effective means of collaboration and a proven approach for helping organizations work together. Collective impact is a network of community members, organizations, and institutions who advance equity by learning together, aligning, and integrating their actions to achieve population and systems level change.

<https://collectiveimpactforum.org/>. Each funded ICO4MCH project is required to utilize a Collective Impact framework and implement the evidence-based strategies (EBS). Within the Collective Impact framework, the development and maintenance of a Community Action Team (CAT) is critical and required. The CAT is composed of local health department representatives (including management), current and former program participants, community members, caretakers, and other representatives including hospital administrators, faith leaders, other public and private maternal and child health providers, as well as additional partners working to improve the population health of women, infants, children, and families. The CAT shall convene at least quarterly during each year of the funding period. The CAT will provide guidance and

expertise to the local health department responsible for managing the ICO4MCH grant during the planning, implementation, and evaluation of the project.

## **HEALTH DISPARITIES**

Health equity is the attainment of the highest level of health for all people (<https://health.gov/healthypeople/priority-areas/health-equity-healthy-people-2030>). Health inequities are preventable differences in health status or risk between different population groups. Health disparities are the differences in health status or outcomes between different population groups. Groups may differ by race, ethnicity, gender, geographic location, disability, immigration status, income, and sex (among others). Health inequities perpetuate health disparities. Health disparities in infant mortality rates, birth outcomes, and child health indicators exist in North Carolina; thereby increasing the inequities our state faces. Each funded ICO4MCH project should utilize stratified local and state data to identify the health disparities among the impacted population(s) within each aim in order to address the root causes of the health inequities that exist. In addition, each funded ICO4MCH project should examine the social determinants of health within each aim to fully understand the health inequities that exist and how to address them. Each section of the application should clearly address health disparities and health inequities that may impact the priority population to be served by the program. A sample resource list of trainings is included in Appendix G of the RFA.

## **COMMUNITY HEALTH WORKERS**

North Carolina public health leaders agree that coordinating efforts to address population health is even more critical than ever. One intervention that is associated with promoting improved health outcomes is the use of community health workers (CHW). The American Public Health Association (APHA) defines a community health worker as “a frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served” whose relationship with the community “enables the worker to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery.” CHWs are uniquely qualified to work with individuals of reproductive age, their children, and families in our efforts to improve community outcomes for maternal and child health. Each applicant is strongly encouraged to incorporate a CHW model in at least one evidence-based strategy to be implemented in the county (ies) to be served.

In May 2018, DHHS released a report entitled, “Community Health Workers in North Carolina: Creating an Infrastructure for Sustainability”. [https://files.nc.gov/ncdhhs/DHHS-CWH-Report\\_Web%205-21-18.pdf](https://files.nc.gov/ncdhhs/DHHS-CWH-Report_Web%205-21-18.pdf). The findings from this report and results of the pilot of the CHW curriculum and certification process can be utilized to train CHWs to work with women of reproductive age, their children, and their families. The ICO4MCH Program recognizes the role of CHWs as the liaison; health navigator; health and wellness promoter and advocate for women and their families in the community. CHWs must complete the certification training. Funds should be allocated in the program budget to pay for training registration and associated travel costs.

## **IMPLEMENTATION SCIENCE**



Newly funded ICO4MCH projects will be required to work with an Implementation Coach from the National Maternal Child Health Workforce Development Center (<https://mchwdc.unc.edu>) during the 1st year of the project period to: 1) increase their understanding of and capacity to use effective Implementation Science practices; 2) support the implementation of the project, using relevant tools, assessments, and methods; 3) provide trouble shooting and guidance as projects evolve; and 4) support projects to measure and improve implementation processes. Newly funded ICO4MCH projects CAT leadership and members should participate in implementation capacity building activities facilitated by Implementation Coaches. Each newly funded ICO4MCH project should expect to work with the Implementation Coach at a minimum of two days per month during the 1st year of the project period. The local ICO4MCH Program Manager shall serve as the primary contact for the Implementation Coach. Applicants who plan to work with National MCH Workforce Development Center should budget \$2,000 per month for the Implementation Coach.

If an existing ICO4MCH project is selected for the June 1, 2024–May 31, 2026 project period, working with the National MCH Workforce Development Center is optional. ICO4MCH sites that are refunded under the new RFA funding cycle, who would like to work with the National MCH Workforce Development Center at any point during the project period, can negotiate a contract based on their needs and goals for the consultation and an estimate of how many days of coaching is required. In this case, the scope of work and budget will be tailored to meet the site's needs. Sites should budget \$500/day based on the number of days of coaching desired.

### **III. GENERAL INFORMATION ON SUBMITTING APPLICATIONS**

#### **1. Award or Rejection**

All qualified applications will be evaluated and awards made to that agency or organization whose combination of budget and service capabilities are deemed to be in the best interest of the funding agency. The funding agency reserves the unqualified right to reject any or all offers if determined to be in its best interest. Successful applicants will be notified by **1/8/2024**.

#### **2. Decline to Offer**

Any agency or organization that receives a copy of the RFA but declines to make an offer is requested to send a written "Decline to Offer" to the funding agency. Failure to respond as requested may subject the agency or organization to removal from consideration of future RFAs.

#### **3. Cost of Application Preparation**

Any cost incurred by an agency or organization in preparing or submitting an application is the agency's or organization's sole responsibility; the funding agency will not reimburse any agency or organization for any pre-award costs incurred.

#### **4. Elaborate Applications**

Elaborate applications in the form of brochures or other presentations beyond that necessary to present a complete and effective application are not desired.

#### **5. Oral Explanations**

The funding agency will not be bound by oral explanations or instructions given at any time during the competitive process or after awarding the grant.

#### **6. Reference to Other Data**

Only information that is received in response to this RFA will be evaluated; reference to information previously submitted will not suffice.

#### **7. Titles**

Titles and headings in this RFA and any subsequent RFA are for convenience only and shall have no binding force or effect.

#### **8. Form of Application**

Each application must be submitted on the form provided by the funding agency and will be incorporated into the funding agency's Performance Agreement (contract).

#### **9. Exceptions**

All applications are subject to the terms and conditions outlined herein. All responses will be controlled by such terms and conditions. The attachment of other terms and conditions by any agency or organization may be grounds for rejection of that agency or organization's application. Funded agencies and organizations specifically agree to the conditions set forth in the Performance Agreement (contract).

**10. Advertising**

In submitting its application, agencies and organizations agree not to use the results therefrom or as part of any news release or commercial advertising without prior written approval of the funding agency.

**11. Right to Submitted Material**

All responses, inquiries, or correspondence relating to or in reference to the RFA, and all other reports, charts, displays, schedules, exhibits, and other documentation submitted by the agency or organization will become the property of the funding agency when received.

**12. Competitive Offer**

Pursuant to the provision of G.S. 143-54, and under penalty of perjury, the signer of any application submitted in response to this RFA thereby certifies that this application has not been arrived at collusively or otherwise in violation of either Federal or North Carolina antitrust laws.

**13. Agency and Organization's Representative**

Each agency or organization shall submit with its application the name, address, and telephone number of the person(s) with authority to bind the agency or organization and answer questions or provide clarification concerning the application.

**14. Subcontracting**

Agencies and organizations may propose to subcontract portions of work provided that their applications clearly indicate the scope of the work to be subcontracted, and to whom. All information required about the prime grantee is also required for each proposed subcontractor.

Agencies and organizations shall also ensure that subcontractors are not on the state's Suspension of Funding List available at: <https://www.osbm.nc.gov/stewardship-services/grants/suspension-funding-memos>.

**15. Proprietary Information**

Trade secrets or similar proprietary data which the agency or organization does not wish disclosed to other than personnel involved in the evaluation will be kept confidential to the extent permitted by NCAC TO1: 05B.1501 and G.S. 132-1.3 if identified as follows: Each page shall be identified in boldface at the top and bottom as "CONFIDENTIAL." Any section of the application that is to remain confidential shall also be so marked in boldface on the title page of that section.

**16. Participation Encouraged**

Pursuant to Article 3 and 3C, Chapter 143 of the North Carolina General Statutes and Executive Order No. 77, the funding agency invites and encourages participation in this RFA by businesses owned by minorities, women and the disabled, including utilization as subcontractor(s) to perform functions under this Request for Applications.

**17. Contract**

The Division will issue a contract in the form of an Agreement Addenda to the recipient of the RFA funding. Expenditures can begin immediately upon receipt of an executed contract.

#### **IV. APPLICATION PROCUREMENT PROCESS AND APPLICATION REVIEW**

The following is a general description of the process by which applicants will be selected for funding for this project.

**1. Announcement of the Request for Applications (RFA)**

The announcement of the RFA and instructions for receiving the RFA will be posted at the following DHHS website on **10/25/2023**:

<http://www.ncdhhs.gov/about/grant-opportunities/public-health-grant-opportunities> and may be sent to prospective agencies and organizations via direct mail, email, and/or the Program's website.

**2. Distribution of the RFA**

RFAs will be posted on the Program's website <https://wicws.dph.ncdhhs.gov/> and may be sent via email to interested agencies and organizations beginning **10/25/2023**.

**3. Bidder's Conference / Teleconference / Question & Answer Period**

All prospective applicants are encouraged to attend a Bidder's Conference on Wednesday **11/1/2023 at 1:30pm-2:30 pm**. The link to the Bidder's Webinar is here: <https://www.zoomgov.com/j/1606206704> Meeting ID: 160 620 6704 or dial 1-646-828-7666 Meeting ID#-160 620 6704#. The link will also be posted on the Women, Infant, and Community Wellness Section website-<https://wicws.dph.ncdhhs.gov/>.

Written questions concerning the specifications in this Request for Applications will be received until 5:00pm on **11/9/2023**. As an addendum to this RFA, a summary of all questions and answers will be emailed by **11/16/2023** to all agencies and organizations will be placed on the Women, Infant, and Community Wellness Section website: <https://wicws.dph.ncdhhs.gov/> website.

**4. Applications**

Applicants shall submit electronically **one original application**. All copies shall include the required attachments. Faxed applications will not be accepted.

**5. Original Application**

The original application must contain original documents, and all signatures in the original application must be original. Mechanical, copied, or stamped signatures are not acceptable.

**6. Format**

The application must be typed, single-side on 8.5" x 11" paper with margins of 1". Line spacing should be single-spaced. The font should be easy to read and no smaller than an 11-point font.

**7. Space Allowance**

Page limits are clearly marked in each section of the application. Refer to *VIII.3 Applicant's Response* for specifics.

**8. Application Deadline**

All applications must be received by the date and time on the cover sheet of this RFA. Faxed or emailed applications ***will not*** be accepted in lieu of the original and required number of hard copies. Original signatures are required. Note: If the US Postal Service is used, allow sufficient time for delivery to the funding agency by 5:00 PM, close of business, on **12/20/2023**.

**9. Receipt of Applications**

Applications from each responding agency and organization will be logged into the system and stamped with the date received on the cover sheet.

**10. Review of Applications**

Applications are reviewed by a multi-disciplinary committee of public and private health and human services providers who are familiar with the subject matter. Staff from applicant agencies may not participate as reviewers.

Applications will be evaluated by a committee according to completeness, content, experience with similar projects, ability of the agency's or organization's staff, cost, etc. The State reserves the right to conduct site visits as part of the application review and award process. The award of a grant to one agency and organization does not mean that the other applications lacked merit, but that, all facts considered, the selected application was deemed to provide the best service to the State. Agencies and organizations are cautioned that this is a request for applications, and the funding agency reserves the unqualified right to reject any and all applications when such rejections are deemed to be in the best interest of the funding agency.

**11. Request for Additional Information**

At their option, the application reviewers may request additional information from any or all applicants for the purpose of clarification or to amplify the materials presented in any part of the application. However, agencies and organizations are cautioned that the reviewers are not required to request clarification. Therefore, all applications should be complete and reflect the most favorable terms available from the agency or organization.

**12. Audit**

Please be advised that successful applicants may be required to have an audit in accordance with G.S. 143C-6-22 and G.S. 143C-6-23 as applicable to the agency's status.

G.S. 143C-6-23 requires every nongovernmental entity that receives State or Federal pass-through grant funds directly from a State agency to file annual reports on how those grant funds were used.

There are 3 reporting levels which are determined by the total direct grant receipts from all State agencies in the entity's fiscal year:

Level 1: Less than \$25,000

Level 2: At least \$25,000 but less than \$500,000

Level 3: \$500,000 or more

Level 3 grantees are required to submit a "Yellow Book" Audit done by a CPA. Only Level 3 grantees may include audit expenses in the budget. Audit expenses should be prorated based on the ratio of the grant to the total pass-through funds received by the entity.

**13. Assurances**

The contract may include assurances that the successful applicant would be required to execute prior to receiving a contract as well as when signing the contract.

**14. Additional Documentation to Include with Application**

All applicants are required to include documentation of their tax identification number.

**15. Unique Entity Identifier (UEI)**

All grantees receiving federal funds must have a Unique Entity Identifier (UEI) which is issued by the federal government in [www.SAM.gov](http://www.SAM.gov). If your agency does not have a UEI, please use the online registration at [www.SAM.gov](http://www.SAM.gov) to receive one free of charge.

**16. Sudan Divestment Act**

The Sudan (Darfur) Divestment Act of 2007, as amended, requires State agencies to divest from investments in companies that are engaged in certain activities in Sudan. Any organization identified engaging in investment activities in Sudan (Darfur), as determined by appearing on the Final Divestment List created by the NC Department of the State Treasurer, is ineligible to contract with the State of North Carolina or any political subdivision of the State. Refer to NC General Statutes Chapter 147 Article 6D.

**17. Iran Divestment Act**

The Iran Divestment Act of 2015, as amended, prohibits State agencies from investing in or contracting with individuals and companies engaged in certain investment activities in Iran. Any organization identified engaging in investment activities in Iran, as determined by appearing on the Final Divestment List created by the NC Department of the State Treasurer, is ineligible to contract with the State of North Carolina or any political subdivision of the State. Refer to NC General Statutes Chapter 147 Article 6E.

**18. Boycott Israel Divestment Policy**

The Divestments from Companies Boycotting Israel Act of 2017, as amended, prohibits State agencies from making investments in, and contracts with, companies that are engaged in a boycott of Israel, as defined by this Act. Any organization that boycotts Israel, as determined by appearing on the Final Divestment List created by the NC Department of the State Treasurer, is ineligible to contract with the State of North Carolina or any political subdivision of the State. Refer to NC General Statutes Chapter 147 Article 6G.

**19. Application Process Summary Dates**

10/25/2023: Request for Applications released to eligible applicants.  
11/01/2023: Bidder's Conference/Teleconference. (webinar)

11/09/2023: End of Q&A period. All questions due in writing by 5pm.  
11/16/2023: Answers to Questions released to all applicants, as an addendum to the RFA.  
12/20/2023: Applications due by 5pm.  
01/08/2024: Successful applicants will be notified.  
06/01/2024: Contract begins.



## V. PROJECT BUDGET

### **Budget and Justification**

Applicants must submit a budget, using the Open Windows budget worksheet, which requires a line-item budget for each year of funding [Year 1 (June 1, 2024–May 31, 2025) and Year 2 (June 1, 2025 – May 31, 2026)] and a narrative justification. An electronic version of the Open Windows budget worksheet can be found at <https://wicws.dph.ncdhhs.gov/>. A copy of the budgets should be submitted with the application.

### **Narrative Justification for Expenses**

A narrative justification must be included for every expense listed in the Year One and Year Two budgets. Each justification should show details of how the amount on the line-item budget was calculated and it should be clear how the expense relates to the program. The instructions on **How to Fill Out the Open Windows Budget Form** are posted on the Women, Infants and Community Wellness Section website at <https://wicws.dph.ncdhhs.gov/>.

### **Travel Reimbursement Rates**

Mileage reimbursement rates must be based on rates determined by the North Carolina Office of State Budget and Management (OSBM). Because mileage rates fluctuate with the price of fuel, the OSBM will release the “Change in IRS Mileage Rate” memorandum to be found on OSBM’s website when there is a change in this rate. The current state mileage reimbursement rate is \$0.655 cents per mile.

For other travel related expenses, please refer to the current rates for travel and lodging reimbursement, presented in the chart below. However, please be advised that reimbursement rates periodically change. The Division of Public Health will only reimburse for rates authorized in North Carolina Department of Health and Human Services Travel Policy. Effective July 1, 2021, the Department of Health and Human Services (DHHS) shall utilize GSA State/City Standard Travel Per Diems as the maximum allowable statutory rate for meals and lodging (subsistence). The following schedule (effective October 1, 2023) shall be used for reporting allowable subsistence expenses incurred while traveling on official state business:

**Current Rates for Travel and Lodging**

<b>Meals</b>	<b>In State</b>	<b>Out of State</b>
Breakfast	\$13.00	\$13.00
Lunch	\$15.00	\$15.00
Dinner	\$26.00	\$26.00
<i>Total Meals Per Diem Per Day</i>	<i>\$54.00</i>	<i>\$54.00</i>
<b>Lodging</b> ( <i>Maximum rate per person, excludes taxes and fees</i> )	\$107.00 + taxes/fees	\$107.00 + taxes fees
<b>Total Travel Allowance Per Day</b>	<b>\$161.00</b>	<b>\$161.00</b>
Mileage	\$0.655 per mile/regardless of distance	

**Audits**

G.S. 143C-6-23 requires every nongovernmental entity that receives State or Federal pass-through grant funds directly from a State agency to file annual reports on how those grant funds were used.

There are 3 reporting levels that are determined by the total direct grant receipts from all State agencies in the entity's fiscal year:

Level 1: Less than \$25,000

Level 2: At least \$25,000 but less than \$500,000

Level 3: \$500,000 or more

Level 3 grantees are required to submit an audit. Only Level 3 grantees may include audit expenses in the budget. Audit expenses should be prorated based on the ratio of the grant to the total pass-through funds received by the entity.

**Indirect Cost**

Indirect costs are not allowed.

## **VI. EVALUATION CRITERIA**

The application is worth 100 points. **The page limit for the narrative sections of the application, including the cover letter, is 40 pages.** Budget pages and endnote pages are not counted in the total page limit. Point values are clearly marked beside each item on the Application Form. The total point value for each section of the application is listed below. A multi-disciplinary team will review the application for both content and quality of responses to each item on the application.

1. Cover Letter (1 point)
2. Health Equity (15 points)
3. Needs Assessment (10 points)
4. Program Plan (21 points)
5. Data Collection and Evaluation (15 points)
6. Agency Ability (15 points)
7. Collective Impact/Community Involvement (15 points)
8. Budget (8 points)

**Each of the content areas will be scored according to the numerical values stated above.**

## **VII. APPLICATION**

### **Application Checklist**

The following items must be included in the application. Please use a binder clip at the top left corner on each copy of the application and assemble the application in the following order:

1.     \_\_\_ **Cover Letter**
2.     \_\_\_ **Application Face Sheet**
3.     \_\_\_ **Applicant's Response/Form**
4.     \_\_\_ **Project Budget**  
          Include a budget in the format provided.  
          Budget Narrative.  
          Indirect costs are not allowed.
5.     \_\_\_ **Letters of Agreement**
6.     \_\_\_ **IRS Letter Documenting Your Organization's Tax Identification Number** (public agencies)

## 1. Cover Letter

The application must include a cover letter, on agency letterhead, signed and dated by an individual authorized to legally bind the Applicant.

Include in the cover letter:

- the legal name of the Applicant agency
- the RFA number
- the Applicant agency's federal tax identification number
- the Applicant agency's Unique Entity Identifier (UEI)
- the closing date for applications.
- the Applicant's mission, background and current services offered.
- indicate a clear understanding of the Improving Community Outcomes for Maternal and Child Health program (ICO4MCH) and a strong commitment of replicating the program requirements.
- state which three evidence-based strategies are selected, one for each of the three program aims.
- the contact information listed on the template.

## 2. Application Face Sheet

This form provides basic information about the applicant and the proposed project with the *Improving Community Outcomes for Maternal and Child Health Program*, including the signature of the individual authorized to sign “official documents” for the agency. This form is the application’s cover page. Signature affirms that the facts contained in the applicant’s response to RFA #A412 are truthful and that the applicant is in compliance with the assurances and certifications that follow this form and acknowledges that continued compliance is a condition for the award of a contract. Please follow the instructions below.

1. Legal Name of Agency:	
2. Name of individual with Signature Authority:	
3. Mailing Address (include zip code+4):	
4. Address to which checks will be mailed:	
5. Street Address:	
6. Contract Administrator: Name: Title:	Telephone Number: Fax Number: Email Address
7. Agency Status (check all that apply):  <input type="checkbox"/> Public <input type="checkbox"/> Private Non-Profit <input type="checkbox"/> Local Health Department	
8. Agency Federal Tax ID Number:	9. Agency UEI:
10. Agency’s URL (website):	
11. Agency’s Financial Reporting Year:	
12. Current Service Delivery Areas (county(ies) and communities):	
13. Proposed Area(s) To Be Served with Funding (county(ies) and communities):	
14. Amount of Funding Requested	
15. Projected Expenditures: Does applicant’s state and/or federal expenditures exceed \$500,000 for applicant’s current fiscal year (excluding amount requested in #14)      Yes <input type="checkbox"/> No <input type="checkbox"/>	
The facts affirmed by me in this application are truthful and I warrant that the applicant is in compliance with the assurances and certifications contained in NC DHHS/DPH Assurances Certifications. I understand that the truthfulness of the facts affirmed herein and the continuing compliance with these requirements are conditions precedent to the award of a contract. The governing body of the applicant has duly authorized this document and I am authorized to represent the applicant.	
16. Signature of Authorized Representative:	17. Date

### **3. Applicant's Response**

#### **Health Disparities (15 points)**

As previously defined, health equity is the attainment of the highest level of health for all people. Health inequities are preventable differences in health status or risk between different population groups. Health disparities are the differences in health risks or status between different population groups. Groups may differ by race, ethnicity, gender, geographic location, disability, immigration status, income, and sex (among others).

Throughout the application, the Applicant must outline how they will ensure the three evidence-based strategies (EBS) will address health disparities in the service area(s) which perpetuate the health inequities identified. Each program aims and EBS should clearly identify how the Applicant will use resources, materials, program planning, implementation, and evaluation to ensure their EBS are addressing the root causes of the disparities within infant mortality, birth outcomes, and infant/child health outcomes.

Within the first six months of funding, the Applicant will conduct a Health Equity Impact Assessment (HEIA) with at least one of the three selected EBS. NOTE: If the Applicant has completed a HEIA or similar assessment that is associated with a maternal and child health program within the local health department, within the past 12 months, DPH will accept this in lieu of conducting a new assessment. The DPH will support each Applicant in the implementation of the HEIA. The HEIA will evaluate the impact of the selected EBS on the local health disparities and provide guidance on how to modify the program and/or evaluation plan. The Applicant will implement the second EBS using the HEIA within the first quarter of the second year of funding. To access a full copy of the HEIA, visit <https://ncchild.org/health-equity-impact-assessment> provides an overview of the HEIA tool and an option to download.

#### **Section 1: Needs Assessment (10 points)**

In order to implement evidence-based strategies (EBS) that are proven to lower infant mortality rates, improve birth outcomes, and improve the overall health status of children ages birth to five in their communities, the applicants must demonstrate an: 1) understanding how health inequities contribute to health disparities in North Carolina among the chosen EBS; 2) understanding of the factors that contribute to high infant mortality rates, particularly among minority populations; 3) understanding of the factors that contribute to poor maternal and infant birth outcomes; 4) understanding of the factors that contribute to improving the health status of children ages birth to five; 5) an assessment of which factors are most relevant for the population they intend to serve; and 6) rationale for the selected EBS and policies that will be implemented to address gaps and unmet needs. All data should be stratified at the county level, whenever possible.

Demographic data, such as race/ethnicity, age, education, and other social determinants of health should be included in the needs assessment.

## **Selection of the Evidence-Based Strategies**

Applicants are required to state which three evidence-based strategies (EBS) they are selecting for each of the three program aims. Applicants must provide a rationale for how these EBS and how the priority population(s) were selected. The EBS must be addressed to meet the needs of the population to be served within the entire county or multi-county area.

## **Evidence of Need**

The infant mortality, birth outcomes, child health insurance, and child poverty criteria described in Section II of this RFA, must convincingly describe and document the need for services. For each EBS, describe the impacted population(s) to be served. Data should be stratified at the county and state level, and, when possible, by race and ethnicity. Data should be compared to other counties and the state. Data provided should be associated with the EBS selected by the agency. Additional information about birth outcomes, infant mortality, and early childhood health may be included beyond these suggestions, including qualitative data (i.e., from focus groups, key informant interviews, etc.). Applicants are encouraged to present data in tables or graphs with a detailed narrative analysis of data (5 points). Please refer to Appendix B for a list of recommended data resources.

- a. Demographic statistics for women who gave birth (i.e., age, education level, health status, pre-pregnancy body mass index, marital status)
- b. Infant mortality and disparity rates
- c. Birth outcomes (i.e., low and very low birth weight rates, preterm birth rates)
- d. Prenatal care (i.e., initiation rates, adequate prenatal care rates)
- e. Child poverty rate (children <5 years of age)
- f. Uninsured child rate (children <19 years of age)
- g. Number of providers in the county or multi-county area that offer LARC
- h. Tobacco use/smoking during pregnancy rates
- i. Breastfeeding initiation rates among women
- j. Description of businesses/organizations that accommodate breastfeeding individuals
- k. Description of county policies regarding tobacco-free workplaces

## **Citations**

Appropriate data sources must be cited in the needs assessment. One way this can be done is by using endnotes. If you use endnotes, the citation list can be included on a separate page and will not count against the page limit for this section. For further information on citing references using endnotes, please refer to the handout posted on the Women, Infant, and Community Wellness Section website titled, "Guidance for Citing Sources in the Needs Assessment," <https://wicws.dph.ncdhhs.gov/>.



## **Section 2: Program Plan (21 points)**

Applicants will be required to describe in detail their program and implementation plan of the three EBS chosen to address the three program aims: reduce infant mortality, improve birth outcomes, and improve health status of children ages birth to five. Applicants should describe their experience with implementing the selected EBS. Applicants will describe how their program will meet or exceed the program service deliverables, and describe the activities involved to meet the deliverables. Applicants will describe how their program will meet each of the program performance outcome measures.

## **Section 3: Data Collection and Evaluation (15 points)**

Applicants will be required to describe how data will be collected and evaluated for each of the three EBS based upon the scope of services and performance measures listed for each EBS. Applicants will describe how they will monitor and evaluate activities and outcomes provided in the proposed program plan, and the type of evaluation tools that will be used (e.g., assessments, pre/post-tests, questionnaires, surveys, data tracking methods/tools, reports). Applicants will describe their policies and procedures for maintaining client confidentiality. Applicants can refer to Appendix E for additional information regarding the data that will be provided by the Applicant and by DPH.

## **Section 4: Agency Ability (15 points)**

Applicants will describe their agency's mission, background, and services and how these relate to the goals of the ICO4MCH Program. Applicants should include their experience working with and implementing maternal and child health programs in the community. The agency's organizational chart must be included in Attachment A.

Applicants must indicate experience that program staff has with the chosen EBS and training they have received or plan to receive if awarded funding. Required trainings are described in the Scope of Services Section for each EBS, if applicable. If program staff is already in place, provide resumes in Attachment A. If program staff is not in place, provide a job description for each program position in Attachment A.

## **Section 5: Collective Impact and Community Involvement (15 points)**

Applicants should describe their experience utilizing the Collective Impact framework in previous maternal and child health programs in the service area. Applicants can include trainings or technical assistance they or others who will be involved with the ICO4MCH project have received within the last two years, as well as past or current outcomes of their work.

If Applicant is planning to incorporate Implementation Science into project, please describe experience in utilizing the principles of implementation science in other public health programs in the service area. Additional applicable information regarding Collective Impact or Implementation Science should be included.

Applicants must provide a list of their current or potential Community Action Team (CAT) members. The CAT is composed of management, consumers, community/family leaders, and

other representatives, which can include hospital executives, faith leaders, maternal and child health providers as well as other partners working to improve the population health of women, infants, children, and families. Potential CAT members must submit a letter of commitment (LOC) outlining their unique role and contribution to the CAT. Current CAT members may utilize the LOC they provided when joining the CAT. LOC must be included in Attachment B.

The CAT must convene at least quarterly. Meeting minutes shall be taken and should include the names of the attendees, along with their organization or role. Minutes should document the role of the CAT in advising, assisting, and collaborating to meet the goals of the ICO4MCH project in the service area.

Applicants are expected to collaborate with other community agencies to assist with implementing the proposed EBS and to refer clients to services that are beyond the scope of the program. A Letter of Agreement (LOA) must be included from each agency that is committed to assist with implementation and/or serve as a referral agency to provide services to clients. Each LOA should include the specific contribution from the agency to the specific evidence-based strategy. All LOA must be included in Attachment C.

#### **4. Project Budget (8 points)**

Additional budgetary items to consider:

##### **Staffing**

Each Applicant must adhere to the following guidelines for staffing the ICO4MCH project, unless otherwise noted in the scope of services: 1.0 FTE Program Manager, and at least one 0.50 FTE per EBS which are paid staff positions. Note: Triple P and Family Connects Newborn Home Visiting Program have specific staffing requirements that must be followed. In addition, staff hired to implement the project can be contract employees and/or salaried employees with this state funding. All applicants should follow county guidelines for hiring.

##### **Implementation Science Costs**

As described in the Scope of Services Section of this RFA, each newly funded ICO4MCH project will be required to budget funds for an Implementation Coach from the National MCH Workforce Development Center for at least the first year of the grant period. Re-funded Applicants are not required to budget funds for an Implementation Coach. The monthly cost for the Implementation Coach is \$2,000 which must be included in the project budget(s). Each project should expect to work with the Implementation Coach at a minimum of two days per month in the early stages of the project.

If an existing ICO4MCH project is selected and decides to work with the National MCH Workforce Development Center at any point during the project period, they can negotiate a contract based on their goals for the consultation and an estimate how many days of coaching is required. In this case, the scope of work and budget must be tailored to the site's needs. Currently funded sites should budget for \$500/day based on the number of days of coaching desired.

## **5. Attachments**

### **Attachment A: Agency Information**

This attachment must include an organizational chart of the local health department. If this is a multi-county proposal, include an organizational chart for each LHD.

### **Attachment B: Letters of Commitment**

This attachment must include LOC from current and/or prospective Community Action Team (CAT) members indicating both their commitment to serve and the responsibilities they will assume as a member of the CAT.

### **Attachment C: Letters of Agreement**

This attachment must include LOA from agencies that are committed to assist with implementation and/or serve as a referral agency for services provided to clients. Each LOA should specify the agency's contribution to the selected evidence-based strategy. An LOA should also be included for any agency that the Applicant will sub-contract with for this project.

### **IRS Letter**

#### ***Public Agencies:***

Provide a copy of a letter from the IRS which documents your organization's tax identification number. The organization's name and address on the letter must match your current organization's name and address.

This IRS determination letter can also satisfy the documentation requirement of your organization's tax identification number.

## **6. Organization of Application**

Follows beginning on next page.

# Cover Letter

**Total Point Value:**

**1**

**Page Limit:**

**2 single-spaced**

The application must include a cover letter, on agency letterhead, signed and dated by an individual authorized to legally bind the Applicant.

Include in the cover letter:

- The legal name of the Applicant agency.
- The RFA number.
- The Applicant agency's federal tax identification number.
- The Applicant agency's UEI number.
- The closing date for applications.
- The Applicant's mission, background and current services offered.
- Indicate a clear understanding of the ICO4MCH project and a strong commitment of replicating the program requirements.
- State which three evidence-based strategies are being chosen; one for each of the three program aims.
- The contact information listed on the template.
- Signed and dated by an authorized individual to legally bind the Applicant.

# Application Form

The application is worth a total of 100 points.

Point values and page limits are clearly marked for each section of the application form.

**Do not delete the question headers** within the application form.

Please provide your response to each question under the heading.

# Section 1

## Needs Assessment

**Do not delete the question headers.**

Please provide your response to each question under the heading.

**Total Point Value:**

**10**

**Page Limit:**

**8 single-spaced, not including citation page(s)**

- 1-1. Define the specific area that will be served by the ICO4MCH project. An area may be a county or multi-county area. (1 point)

For each evidence-based strategy (EBS), provide recent data to demonstrate the need for the ICO4MCH project in the county or multi-county area you propose to serve. For each EBS, describe the impacted population(s) to be served. Data should be stratified at the county and state level, and, when possible, by race and ethnicity. Data should be compared to other counties and the state. Data provided should be associated with the EBS selected by the agency. Additional information about birth outcomes, infant mortality, and early childhood health may be included beyond these suggestions, including qualitative data (i.e., from focus groups, key informant interviews, etc.). Applicants are encouraged to present data in tables or graphs with a detailed narrative analysis of data (5 points).

- a. Demographic statistics for individuals who gave birth (i.e., age, education level, health status, pre-pregnancy body mass index, marital status)
- b. Infant mortality and disparity rates
- c. Birth outcomes (i.e., low and very low birth weight rates, preterm birth rates, etc.)
- d. Prenatal care (i.e., initiation rates, adequate prenatal care rates, etc.)
- e. Child poverty rate (children <5 years of age)
- f. Uninsured child rate (children <19 years of age)
- g. Number of providers in the county or multi-county area that offer LARC
- h. Tobacco use/smoking during pregnancy rates
- i. Breastfeeding initiation rates among individuals
- j. Description of businesses/organizations that accommodate breastfeeding individuals
- k. Description of county policies regarding tobacco-free workplaces

- 1-2. Describe the availability and accessibility of health services and other support services in the community that impact the three aims. Describe strengths, barriers, and gaps in

services. Services should include both internal and external health and other support services to the LHD. (2 points)

- 1-3. For each EBS, describe how the impacted/priority population was identified. (2 points)
- 1-4. Appropriate data sources must be cited in the needs assessment. The citation list can be included on a separate page and will not count against the page limit for this section.

# Section 2

## Program Plan

**Do not delete the question headers.**

Please provide your response to each question under the heading.

**Total Point Value:**  
**21**

**Page Limit:**  
**12 single-spaced**

- 2-1. Restate the three EBSs your agency will implement to address each of the three program aims. (1 point)
- 2-2. For each EBS, describe how the Applicant will implement and potentially exceed the scope of services, performance measures, and reporting requirements. In the description, include detailed activities for each EBS. Information such as who will oversee each EBS and the activities, what activities will take place, where and when activities will be implemented, etc. Applicants are encouraged to use tables to clearly identify each EBS, scope of service, performance measure, activities, etc. (11 points)
- 2-3. For each EBS, describe how the impacted/priority population(s) has been or will be involved in the program planning, implementation, and evaluation. (3 points)
- 2-4. Describe your experience implementing maternal and child health EBS. In the description, include how your agency has collaborated with other organizations; how your agency will collaborate with other organizations to implement the three EBS chosen for the ICO4MCH project. (3 points)
- 2-5. For each EBS, what change do you expect to see because of the implemented strategies? (2 points)
- 2-6. For each EBS, which factors will the intervention impact? (Check all that apply) (1 point)



Evidence-based strategy	Impacted area(s)
1. _____	<input type="checkbox"/> Housing <input type="checkbox"/> Jobs & Economic Stability <input type="checkbox"/> Neighborhood & Community Supports <input type="checkbox"/> Health & Health Care <input type="checkbox"/> Public Services & Supports <input type="checkbox"/> Education <input type="checkbox"/> Criminal Justice <input type="checkbox"/> Environment <input type="checkbox"/> Other _____
2. _____	<input type="checkbox"/> Housing <input type="checkbox"/> Jobs & Economic Stability <input type="checkbox"/> Neighborhood & Community Supports <input type="checkbox"/> Health & Health Care <input type="checkbox"/> Public Services & Supports <input type="checkbox"/> Education <input type="checkbox"/> Criminal Justice <input type="checkbox"/> Environment <input type="checkbox"/> Other _____
3. _____	<input type="checkbox"/> Housing <input type="checkbox"/> Jobs & Economic Stability <input type="checkbox"/> Neighborhood & Community Supports <input type="checkbox"/> Health & Health Care <input type="checkbox"/> Public Services & Supports <input type="checkbox"/> Education <input type="checkbox"/> Criminal Justice <input type="checkbox"/> Environment <input type="checkbox"/> Other _____

# Section 3

## Data Collection and Evaluation

**Do not delete the question headers.**

Please provide your response to each question under the heading.

**Total Point Value:**  
**15**

**Page Limit:**  
**9 single-spaced**

- 3-1. For each evidence-based strategy (EBS), describe how your agency will monitor and evaluate the performance measures. Include past experiences, monitoring and evaluating similar maternal and child health programs. (4 points)
- 3-2. For each EBS, describe the evaluation tools that will be used to monitor and evaluate each activity described in your program plan (e.g., assessments, pre/post-tests, questionnaires, surveys, data tracking methods/tools, reports). Refer to Appendix E that identifies the data that can be provided by the DPH. (10 points)
- 3-3. Describe how you will maintain client confidentiality for each of the selected three EBS. (1 point)

# Section 4

## Agency Ability

**Do not delete the question headers.**

Please provide your response to each question under the heading.

**Total Point Value:**  
**15**

**Page Limit:**  
**3 single-spaced**

- 4-1. Describe your agency's mission, background, and services and how these relate to the program aims for ICO4MCH. Applicants should include their experience working with and implementing maternal and child health programs in the community. Include the agency's organizational chart in Attachment A. (5 points)
- 4-2. Describe the agency's staff that will oversee the grant funds (budgeting, billing, sub-contracts, contract expenditure reports, etc.), if awarded. (5 points)
- 4-3. Use the chart below to list the current and/or new staff positions that will be necessary to implement and support the three EBS. For each staff listed, please highlight their qualifications, FTE, or percent effort on the ICO4MCH project and which EBS they will be working with. Administrative, management staff, or in-kind staffing should be accounted for in the chart below. Please insert additional rows, if needed. Include copies of job descriptions of future staff and/or resumes of current staff in Attachment A. (5 points)

Evidence-based strategy	Position Title	Current Employee Name. If employee is to be hired, put TBD	Briefly highlight qualifications for position or involvement	Full Time Equivalency (FTE)	Percent (%) of time dedicated to EBS	Check the box to indicate if the correct classification	Check the correct box to indicate which is included in Attachment A
						<input type="checkbox"/> Current staff <input type="checkbox"/> New Hire	<input type="checkbox"/> Job Description <input type="checkbox"/> Resume
						<input type="checkbox"/> Current staff <input type="checkbox"/> New Hire	<input type="checkbox"/> Job Description <input type="checkbox"/> Resume
						<input type="checkbox"/> Current staff <input type="checkbox"/> New Hire	<input type="checkbox"/> Job Description <input type="checkbox"/> Resume
						<input type="checkbox"/> Current staff <input type="checkbox"/> New Hire	<input type="checkbox"/> Job Description <input type="checkbox"/> Resume
						<input type="checkbox"/> Current staff <input type="checkbox"/> New Hire	<input type="checkbox"/> Job Description <input type="checkbox"/> Resume
						<input type="checkbox"/> Current staff <input type="checkbox"/> New Hire	<input type="checkbox"/> Job Description <input type="checkbox"/> Resume
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						<input type="checkbox"/> Current staff <input type="checkbox"/> New Hire	<input type="checkbox"/> Job Description <input type="checkbox"/> Resume
						<input type="checkbox"/> Current staff <input type="checkbox"/> New Hire	<input type="checkbox"/> Job Description <input type="checkbox"/> Resume
						<input type="checkbox"/> Current staff <input type="checkbox"/> New Hire	<input type="checkbox"/> Job Description <input type="checkbox"/> Resume

# Section 5

## Community Involvement/ Collective Impact

**Do not delete the question headers.**

Please provide your response to each question under the heading.

**Total Point Value:**

**15**

**Page Limit:**

**7 single-spaced**

- 5-1. Describe how the Community Action Team (CAT) or other stakeholders from the community were involved in the selection of the evidence-based strategies (EBS), the program, implementation, and evaluation plans. Include information on how the CAT or other stakeholders from the community with maternal and child health programs will be involved in the ICO4MCH project. (4 points)
- 5-2. Describe how the agency will collaborate with community members, consumers, advocates, content experts, other health and human service agencies, and community or faith-based organizations to implement the three EBS. The Collective Impact framework should be addressed when describing this collaboration. (4 points)
- 5-3. Use the chart below to identify the CAT members currently collaborating with the LHD. Identify their name, role, and how long they have been involved with the CAT. Roles includes community members, content experts, health care providers, local health department staff, impacted groups, community leaders, or advocates. Provide a letter of commitment from each member in Attachment B.

If the agency does not have a CAT or similar team, use the chart below to identify potential stakeholders from the county/community and what their role will be in implementation of the EBS. Include LOC in Attachment B.

Please insert additional rows if needed. (3 points)

Participant Name	Role & Affiliation	Length of participation (months/years)	LOC Attached?
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No

			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No

- 5-4. Use the chart provided to list the other health and human service agencies, and community or faith-based organizations that will assist with implementing the EBS. Organizations may include those that will sub-contract with the Applicant to provide services associated with the EBS, assist in services such as referrals, transportation, childcare, programming, training, etc.

Include a Letter of Agreement (LOA) from each agency describing their contribution to the specific EBS. Include the LOA in Attachment C.

Please insert additional rows if needed. (4 points)

Organization	Services Provided	EBS focus	Sub-Contract?	LOA Attached?
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Note: It is possible that a collaborating agency may also be a CAT member. If so, one letter (either a LOC or LOA) is acceptable. Identify in the chart where the LOC or LOA can be found.

# Section 6

## Budget

**Total Point Value:**

**8**

**Page Limit:**

**Not Applicable**

Applicants must complete the Open Windows Budget Form for Year 1 (6/1/24 through 5/31/25) and Year 2 (6/1/25 through 5/31/26). Applicants must ensure that all worksheet cells are expanded to expose the full narrative justification. Do not copy Year 1 budget into Year 2 budget. Please consider the needs for each year of the budget. The Open Window Budget Form can be downloaded from the Women, Infant, and Community Wellness Section's website at <https://wicws.dph.ncdhhs.gov/>.

A narrative justification must be included for every expense listed in the Year 1 and 2 budgets. Each justification should show how the amount on the line-item budget was calculated and clearly state how the expense relates to the program. The instructions on **How to Fill Out the Open Windows Budget Form** are posted on the Women, Infant and Community Wellness Section's website at <https://wicws.dph.ncdhhs.gov/>.

The legislation authorizing this program requires "that the Division prioritize grant awards to those local health departments that are able to leverage non-State funds in addition to the grant award." Funding award for Year 1 and 2 will be the same amount.

Applicants should describe how they plan to leverage non-state funds in a narrative. This should include an approximate amount of funding, and source find the narrative as they relate to the program plan. This is not a match requirement, but a statement of local support for the services to be carried out.

# **Attachment A**

## **Agency Information**

This attachment must include each of the following:

- Organizational chart of the applying agency.
- Job descriptions of new staff and/or resumes of current staff, including in-kind staff.



# **Attachment B**

## **Community Involvement/ Collective Impact**

This attachment must include each of the following:

- Letters of Commitment from existing or potential Community Action Team (CAT) members or stakeholders

Note: It is possible that a collaborating agency may also be a CAT member. If so, one letter (either a LOC or LOA) is acceptable.

# **Attachment C**

## **Letters of Agreement**

This attachment must include each of the following:

- Letters of Agreement (LOAs) from organizations who will be sub-contracting, providing services, referrals, etc., with agency.

Note: It is possible that a collaborating agency may also be a CAT member. If so, one letter (either a LOC or LOA) is acceptable.

## **Appendix A: Evidence-Based Strategy Scope of Services, Performance Measures, and Report Requirements**

### **PROGRAM AIM 1: Improve Birth Outcomes**

#### **I. Using a Reproductive Justice Framework to improve the utilization of reproductive life planning (RLP)**

Reproductive Justice is a framework built on the belief in the “complete physical, mental, spiritual, political, economic, and social well-being of women and girls”.<sup>1</sup> It is also the recognition that historically, women, girls, and individuals have experienced reproductive abuses based on “race, ability, class, gender, sexuality, age, and immigration status”.<sup>2</sup> These abuses have resulted in harmful outcomes that have lasting community effects.<sup>1</sup>

Reproductive Life Planning (RLP) is a strategy that aims to encourage both women and men to reflect on their reproductive intentions and to find family planning strategies that function for them.<sup>1</sup> The guidelines associated with RLP seek to develop a set of standardized questions to guide conversations with patients that would support a life course perspective.<sup>5</sup> The Centers for Disease Control and Prevention (CDC) recommend the use of RLP questions with all clients “receiving contraceptive, pregnancy testing and counseling, basic infertility, sexually transmitted disease and preconception health services...”<sup>6</sup>

Paired with the RLP strategy, the Reproductive Justice framework will provide additional resources to health care professionals (clinical and non-clinical) as well as men and women of reproductive age to engage in decisions about their reproductive future. Based on this framework all women should 1) have access to their contraception method of choice, 2) be able to decline a contraception method without judgement or pressure and 3) have access to contraception removal services when they desire.<sup>3,4</sup>

Long-acting reversible contraception (LARC) methods are effective for three to 10 years, and do not require any action on the part of the user after insertion. LARCs include hormonal intrauterine devices (IUDs) such as Mirena®, Skyla®, Liletta® and Kyleena®; the non-hormonal IUD known as ParaGard®; and the implant known as Nexplanon®. Research shows that more patients opt to use a LARC when it is in stock and available for same-day insertion.<sup>7</sup>

Tiered contraceptive counseling is a recommended best practice per the Providing Quality Family Planning Services guidelines, developed by the CDC and the U.S. Office of Population Affairs.<sup>8</sup> The evidence supports increased use of LARCs and a substantial reduction in unintended pregnancy when the tiered approach to contraceptive counseling is utilized.<sup>8,9</sup>

The Oregon Foundation for Reproductive Health developed and tested the One Key Question® for primary care providers.<sup>10</sup> Asking “Would you like to become pregnant in the next year” opens a discussion with patients to begin assessing their RLP as part of their overall life plan.

For same-day insertion to be viable, health care practices/clinics/local health departments must have sufficient numbers of trained health care providers and staff to facilitate clinic flow, and must stock LARC devices in advance rather than purchasing a particular device for a particular patient. Programs for the uninsured, such as Access and Resources in Contraceptive Health (ARCH) Patient Assistant Program, supply Bayer brand IUDs at no cost for specific patients who apply. Health care practices may opt to order devices for specific patients under their pharmacy benefit, which can create barriers for the patient, since this practice generally requires

more than one provider visit. Patients that receive Medicaid can have LARC devices provided from stock and the providers can bill Medicaid for reimbursement. For more information, visit: Obstetrics and Gynecology Clinical Coverage Policies (1E-7): [https://files.nc.gov/ncdma/documents/files/1E7\\_1.pdf](https://files.nc.gov/ncdma/documents/files/1E7_1.pdf)

### **A. Scope of Services**

Offer educational workshops and trainings, within the LHD and at other public/private health care facilities to educate women and men of reproductive age about family planning methods, such as LARCs, using the reproductive justice approach and evidence-based and evidence-informed protocols, such as reproductive life planning (RLP), which may include One Key Question® and a tiered approach to contraceptive counseling. Topics for participants include the principles and application of Reproductive Justice, patient centered and culturally sensitive counseling, learning how access to family planning methods, such as LARCs; potential side effects; informed consent and confidentiality.

Involve consumers of service (men and women of reproductive age) in developing and implementing educational materials, protocols, policies, and strategies to increase access to RLP and family planning methods, including LARCs.

Provide outreach and awareness to members of the community-at-large about the benefits, potential side effects, and informed consent surrounding family planning methods, including LARCs, within the framework of reproductive justice, using the principles of RLP.

Collaborate with other entities, such as your regional Area Health Education Center (AHEC) and Upstream NC, to educate and train health care providers, staff at the LHD, and other public/private health care facilities. Education and training may include the utilization of reproductive justice framework and evidence-informed principles of RLP, utilization of the One Key Question® as well as a tiered approach, implicit bias, and patient centered and culturally sensitive counseling to all patients of reproductive age.

Provide same-day availability and insertion (when applicable) for LARC methods at the local health department.

Provide training, resources, and technical assistance to increase access to same-day insertion of LARC and the availability of full range birth control methods at the LHD, community health clinics, and private healthcare facilities. Training can include insertion and removal of IUDs/implants, tiered counseling, informed consent, and possible side effects for a full range of birth control methods. Reimbursement/billing procedures and the Be Smart Family Planning Program should also be included. Furthermore, encouraging collaboration is highly recommended to provide or assist with trainings. Potential collaborators include AHEC and Upstream NC ([www.upstream.org](http://www.upstream.org)).

### **B. Performance Measures**

Conduct education with a minimum of 300 women and men of reproductive age, using a reproductive justice framework, about family planning methods, including LARCs, reproductive life planning (RLP), and a tiered approach to contraceptive counseling.

Conduct outreach and awareness based on the reproductive justice framework, to a minimum of 1,000 members of the community-at-large about the benefits, potential side effects, and informed consent of family planning methods, specifically, LARCs.

<p>Increase the number of trainings offered to LHD providers and other public/private health care providers. Topics include insertion/ removal of IUDs/implants, billing and reimbursement, tiered contraceptive counseling, postpartum IUD/implant insertion, clinic flow, and other topics as relevant.</p>
<p>Increase the percent of LHD providers who provide consistent and regular same-day insertion of LARCs when requested.</p>
<p><b>C. Reporting/Monitoring Requirements</b>  Funded local health departments shall document and submit data on the following requirements:</p>
<p>The number of women and men of reproductive age educated during workshops/trainings. Data should include topic of the workshop/training, location, basic demographic information (name, age, race, ethnicity), and resources distributed.</p>
<p>The number of community members who receive outreach and awareness. Data should include topics discussed, location, basic demographics, and resources shared.</p>
<p>The number of LHD and other public/private health care providers who participate in an in-person or webinar training or technical assistance with regards to any of the following topics: insertion/removal of IUDs/implants, tiered contraceptive counseling, motivational interviewing, postpartum IUD/implant insertion, reproductive justice or implicit bias.</p>
<p><i>NOTE: Other private/public health care providers or facilities include, but are not limited to: federally qualified community health centers (FQHC), OB/GYN, family medicine, pediatric practice, rural/migrant health centers, etc.</i></p>
<p><b>2. Preconception and Interconception Health</b></p>
<p>Most efforts to reduce infant and maternal mortality have historically focused on prenatal care and interventions during labor and delivery. Unfortunately, after several decades of emphasis in this area, birth outcomes are not improving as much as expected. The importance of prenatal care and delivery management cannot be overstated, but there remain many additional ways to make a great impact on improving birth outcomes for mothers and babies. However, these supports, and services needs to happen prior to pregnancy. (<a href="http://beforeandbeyond.org/wp-content/uploads/2017/01/Zero-to-Three-Article-for-Dr.-Frayne.pdf">http://beforeandbeyond.org/wp-content/uploads/2017/01/Zero-to-Three-Article-for-Dr.-Frayne.pdf</a> )</p> <p>Preconception health refers to the health of women and men during their reproductive years, which are years they can have a child. It focuses on taking steps now to protect the health of a baby they might have sometime in the future. Preconception care is aimed at identifying and modifying physical, behavioral and social risks through preventive and management interventions. (<a href="https://www.cdc.gov/preconception/overview.html">https://www.cdc.gov/preconception/overview.html</a>)</p> <p>Common modifiable risk factors in women that influence birth outcomes for themselves and the baby include: pregnancy intention, interpregnancy interval, maternal age, folic acid supplementation and other nutritional factors, exposure to substances, chronic disease control and toxic stress. For men, preconception health interventions should be focused on reproductive planning and contraception, infection/immunizations, genetics/family history, social and behavioral issues and interpersonal violence. Engaging men during the preconception period is an excellent opportunity to discuss their important role in parenting.</p>
<p><b>A. Scope of Services</b></p>

Implement a community-based health education and outreach program for women of reproductive age and/or women during the interconception period in partnership with a community partner. The program should provide opportunities for women to build social support, learn health information, adopt healthy life skills, become knowledgeable of resources and increase motivation to adopt health improving behaviors. To address issues prevalent during the preconception and/or interconception periods, program content should include, but limited to 1) Healthy Eating/Active Living, 2) Mental Health, and 3) Relationships
Implement the <b>Mothers and Babies Program</b> designed to promote healthy mood management while teaching pregnant women and new moms how to effectively respond to stress in their lives through increasing the frequency of thoughts and behaviors that lead to positive mood states. Mothers and Babies offers a “toolkit” of approaches for women to observe their mood, note factors affecting their mood, and make changes in their daily lives to impact these areas. ( <a href="http://www.mothersandbabiesprogram.org/mothers-clients/">http://www.mothersandbabiesprogram.org/mothers-clients/</a> )
Utilize social media, along with radio, television, billboards, web banners or newspapers to increase public awareness of preconception and interconception health. Campaigns should promote information and behaviors that can improve birth outcomes, such as reducing tobacco use, starting prenatal care within first trimester, responsible use of alcohol, healthy diet and optimal weight, value of postpartum visit, resources that support maternal and paternal mental wellness, breastfeeding support, and reproductive life planning (RLP).
<b><i>Select one (1) of the following Scope of Services to implement in addition to the above listed activities:</i></b>
1. Establish a partnership with local community colleges or four-year universities or agencies that serve women and men of reproductive age to implement a <b>Preconception Health Peer Educator program (PPE)</b> . The PPE program was initiated by the U.S. DHHS Office of Minority Health to train and raise awareness among college students about healthy behaviors that can impact birth outcomes and the social determinants of health that impact health disparities. The PPE program aims to reach college-aged students with targeted health messages emphasizing preconception health and care. These PPE student groups are led by a college/university faculty member or staff. The goals of the PPE program are to: <ul style="list-style-type: none"> <li>a. Train college students as peer educators</li> <li>b. Arm the peer educators with materials, activities and exercises to train their peers in college and in the community at large.</li> <li>c. Reach the college-age population with targeted health messages emphasizing preconception health and healthcare</li> <li>d. Provide targeted health messages to and activities for non-college women and men, ages 18 – 30 years old, within the funded county(ies).</li> </ul>
2. Enhance efforts in promoting and increasing utilization of pre-pregnancy services by women and men of reproductive age, including under-and un-insured, to reinforce the importance of pregnancy planning and preparedness among women and men in the Local Health Department Family Planning clinic or within other primary care practices. This visit should include: physical assessment, completion of the reproductive life plan tool/assessment and provide education and/or referral on folic acid supplementation, oral health, healthy diet and optimal weight, family and genetic history, social and behavioral history, chronic disease management, physical/sexual/emotional abuse and importance of early prenatal care. Funds may support the provision of pre-pregnancy services for women and men of reproductive age, including under- and un-insured clients, or funds may be used to implement strategies to identify individuals in the community who would benefit from these services and raise awareness of pre-pregnancy services available. (Source: <a href="https://www.aafp.org/about/policies/all/preconception-care.html">https://www.aafp.org/about/policies/all/preconception-care.html</a> )
<b>B. Performance Measures</b>

Increase the number of unduplicated men and women of reproductive age and/or during interconception who receive education, support, and information to increase the awareness and adoption of healthy eating and active living skills as well as enhanced mental wellness.
Increase the number of women and men of reproductive age who complete a reproductive life plan assessment.
Facilitate a minimum of 25 Mothers and Babies sessions with women and/or men of reproductive age
Increase the presence of social media messages that provide information about issues related to preconception and interconception health.
<b><i>Select the appropriate performance measure to match the selected scope of service above:</i></b>
1a. Coordinate with the DPH Program Manager or designee to plan and conduct two PPE trainings.
1b. Develop a written agreement with a minimum of 2 partnering community colleges, universities and/or organizations that serve women and men of reproductive age to implement the PPE program. Agreement components shall include: <ul style="list-style-type: none"> <li>a. Identify a PPE advisor at each community college, university and/or agency. The PPE advisor will oversee student PPE outreach on their campus.</li> <li>b. Recruit and maintain a minimum of 10 PPE students each academic year. These PPE students will serve as peer educators to reach their peers with targeted health messages emphasizing preconception health and healthcare.</li> <li>c. Develop and carry out a PPE workplan consisting of at least two on-campus and two community activities each academic year.</li> </ul>
2. Increase the percent of LHDs providing a pre-pregnancy visit for women and men of reproductive age.
<b>C. Reporting Requirements</b>
Funded local health departments shall document and submit data on the following requirements: <ul style="list-style-type: none"> <li>a. The number of unduplicated women of reproductive age and/or during interconception who receive education, support, and information to increase the awareness and adoption of healthy eating and active living skills as well as enhanced mental wellness.</li> <li>b. Number of RLP assessments/tool completed by program participants</li> <li>c. The number of women and men of reproductive age reached through the Mothers and Babies program. Data should include format (one-on-one or group); basic demographic information, and resources/referrals made.</li> </ul>
<b><i>Select appropriate reporting requirement to match the selected scope of service above:</i></b>

### **3. Doula Services**

A doula is a trained professional that provides physical, emotional, and informational support to a woman before, during and after childbirth, including continuous labor support. Evidence supports those women who use a birth doula are less likely to have a cesarean birth; less likely to use Pitocin during labor; and more likely to rate greater satisfaction with her birth experience. Studies also show that doula support can improve preterm birth and low birthweight rates among non-Hispanic Black women and play a role in reducing racial/ethnic disparities in birth outcomes.

#### **A. Scope of Services**

1. Program activities shall include: developing policy and procedures for the program; developing educational and advertising materials for the program; establishing collaborative relationships with local birth facilities; conducting outreach and recruitment of community members to be trained as doulas; coordinating the trainings required for community members to serve as doulas; purchasing training and educational materials, and incentive items; conducting community outreach and education; educating local hospitals, LHD staff and maternity patients on the program; providing supervision and support to contracted doulas; matching doulas with pregnant women; conducting three-month follow-up contacts with program participants and completing birth satisfaction surveys; and tracking program data and completing program reports.
2. Coordinate two (2) required trainings for the community members recruited to be trained as doulas. The required trainings include a one (1) day introduction to childbirth education for doulas course and a two (2) day birth doula workshop. Program budgets must include the cost for both trainings. The estimated cost for both required trainings is \$600 per person.
3. Develop a written doula services agreement with each trained doula that will include: the responsibilities of both parties, the stipend amount to be paid for providing doula services before, during and after childbirth, and the doula's required time commitment to the program.
4. Provide complete doula services for each enrolled participant, which includes a minimum of one (1) prenatal visit, the provision of childbirth education, continuous onsite labor support at the hospital, at least one (1) postpartum visit either in the hospital or within one (1) week after birth, and at least one (1) telephone contact within 30 days after birth.
5. Collect data on program participants and report on a biannual basis. Program participant data shall include demographic information, prenatal care visits, breastfeeding initiation and duration, delivery outcomes, and birth outcomes.
6. Administer a birth satisfaction survey to each Doula Services program participant. All birth satisfaction survey responses shall be entered into an online survey provided by the DPH Contract Administrator. A copy of the Doula Services birth satisfaction survey can be found in Appendix G.
7. Develop and administer a program participant satisfaction survey to evaluate program services and submit an annual satisfaction survey summary report.

#### **B. Performance Measures**

1. At least four (4) community members shall be trained as doulas.
2. At least 40 unduplicated pregnant women shall receive complete doula services, at least 50% shall represent a minority population.
3. At least 75% of program participants shall complete a birth satisfaction survey.
4. At least 80% of program participants shall report a positive birth experience.
5. At least two (2) community outreach and education activities shall be conducted by the Program Coordinator.



## **C Reporting Requirements**

Funded local health departments shall document and submit data on the following requirements:

1. The number of persons who successfully completed doula training.
2. The number of unduplicated pregnant women who received doula services.
3. The number of program participants by age, race and ethnicity who receive doula services.
4. The number of program participants who completed a survey reporting a positive birth experience with their doula.
5. The number of community and educational activities carried out

## **PROGRAM AIM 2: Reduce Infant Mortality**

### **1. Tobacco Cessation and Prevention**

Tobacco use (inclusive of electronic nicotine devices such as e-cigs and vaping pens), screening and counseling should be provided to all pregnant and postpartum women at each health care visit. All clients should be assessed for primary, secondary, and tertiary exposure to tobacco use/smoking (including electronic nicotine devices and vaping). If a client reports tobacco use/smoking, the approved 5A's method of cessation counseling should be offered. The 5A's (Ask, Advise, Assess, Assist, Arrange) is the evidence-based, best practice approach for tobacco cessation. Clients should be referred to QuitlineNC (1-800-QUIT-NOW) and/or appropriate community resources. As clinically appropriate, clients should be offered Food and Drug Administration (FDA) approved tobacco treatment pharmacotherapy support. Evidence supports that a combination of tobacco cessation counseling and pharmacotherapy increases quit rates. Counseling on the risks of second- and third-hand smoke exposure should also be provided during all health care visits.

To increase the capacity of staff to provide tobacco cessation services in the clinical setting, LHDs should send key staff to become certified tobacco treatment specialists (CTTS, Council on Tobacco Treatment Specialist, <http://ctttp.org/>). Research has found that tobacco cessation counseling that is delivered by a variety of clinician types, including physicians and non-physicians, increases quit rates. Tobacco cessation resources are available to assist projects with incorporating tobacco cessation screening, counseling, and documentation: Treating Tobacco Use and Dependence Clinical Practice Guideline 2008 Update <http://www.ahrq.gov/professionals/clinicians-providers/guidelines-recommendations/tobacco.index.html>; and tools for tobacco cessation can be found at <http://publichealth.nc.gov/lhd/>.

In addition to providing direct clinical support around primary, secondary, and tertiary tobacco use/smoking screening, and counseling, LHDs should engage in evidence-based policy support efforts that limit second- and thirdhand smoke exposure. Evidence-based interventions include but are not limited to:

Local regulations that make local government buildings, grounds, and public places tobacco free.

Smoke-free multi-unit housing that also bans e-cigarettes, including public housing, affordable housing, and as resources allow, market rate housing, Tobacco-free colleges and community colleges, local tobacco-free mental health, and substance abuse facilities along with evidence-based tobacco treatment provided by counselors, and tobacco-free childcare centers.

Mass health communication interventions are effective in reducing initiation of tobacco and increasing quit attempts. LHDs should investigate ways to develop and implement earned and paid media opportunities to educate the public and decision-makers about the dangers of tobacco use, secondhand smoke exposure and evidence-based interventions to reduce tobacco use and secondhand smoke exposure among target

populations. For more information, please refer to the <a href="http://www.thecommunityguide.org">www.thecommunityguide.org</a> or <a href="http://www.tobaccopreventionandcontrol.ncdhhs.gov/">www.tobaccopreventionandcontrol.ncdhhs.gov/</a>
<b>A. Scope of Services</b>
Train at least four key licensed professionals (physicians and non-physicians), along with a key staff/leader from a local health system, to become certified tobacco treatment specialists (CTTS) through the Duke-UNC CTTS Program or another nationally accredited CTTS Program. At least 25% of trained CTTS should be from facilities external to the LHD. Maintain engagement, collaboration, and opportunities for additional training with previously trained CTTS.
Refer at least 75% of clients who use tobacco or have secondhand smoke exposure from the local health departments and/or private providers' offices such as OB/GYN, pediatric offices, family medicine, FQHC/community/rural/migrant health centers/clinics to the QuitlineNC (1-800-784-8669) and/or the National Institute of Health's Smoke-Free text line support line (SmokefreeTXT, text QUIT to 47848).
Integrate approved tobacco treatment pharmacotherapy or Nicotine Replacement Therapy (NRT) in LHD and non-LHD clinic services, when clinically appropriate.
Assess 100% of all men and women, caretakers/for tobacco/smoke use, including electronic nicotine devices, such as, e-cigs vaping, and second- and third-hand smoke exposure during each health care visit.
Using the 5As (Ask, Advise, Assess, Assist, Arrange) method, provide a minimum of six trainings for local health department health care providers and staff, private health care providers and staff (such as OB/GYN, pediatric offices, family medicine, FQHC/community/rural/migrant health centers/clinics), and other stakeholders (health educators, peer counselors, outreach workers, and volunteers/staff from faith-based and/or community-based organizations, schools, community colleges, four-year college, universities, etc.) on tobacco/smoking cessation counseling.
Using the 5As (Ask, Advise, Assess, Assist, Arrange) method, within the local health department health care providers and staff, private health care providers and staff (such as OB/GYN, pediatric offices, family medicine, FQHC/community/rural/migrant health centers/clinics), provide tobacco use/smoking screening and cessation counseling to 100% of all pregnant and postpartum women who use tobacco and to at least 50% of all adults, children, and youth who use tobacco during all health care visits.
Document at least 50% of patients' tobacco use/smoking (inclusive of electronic nicotine delivery systems, such as e-cigs and vaping pens) and second- and third-hand smoke exposure status in the client's electronic medical record (EMR) at the initial visit and at every follow-up visit.
Document the use of the 5A's counseling, type and amount of tobacco used, outcome of counseling session (plan of action including referral and follow-up), and length of service provided in at least 50% of all client's electronic medical record. The length of service should follow the guidelines in the Treating Tobacco Use and Dependence Clinic Practice Guideline 2008 Update.
Engage in evidence-based policy support efforts that promote 100% smoke-free or tobacco-free government buildings, groups, and public places. Locations may include, but are not limited to: public and private work sites/businesses, schools, community colleges, four-year colleges/universities, public outdoor spaces, etc.
Engage in evidence-based support efforts with at least five businesses/work sites to increase the number of cessation programs and/or contracts with the QuitlineNC.
Develop and/or utilize existing advertisements to implement paid and earned media opportunities to educate the public and decision-makers about the dangers of primary, secondary, and tertiary tobacco/smoke exposure in the service area(s). Locations may include but are not limited to community colleges and four-year colleges/universities, community-based organizations, faith-based organizations, work sites, and businesses.
<b>B. Performance Measures</b>
Decrease the percentage of pregnant women who smoke by 5%.

Increase the number of health care professionals that incorporate the 5A's (ask, advice, assess, assist, arrange) smoking cessation and counseling method into their clinical setting by 5%.
Increase the number of public policies for smoke-free or tobacco-free workplaces and other indoor public places within the service area(s) by 20%.
Increase the number of worksites within the service area(s) with a cessation program or a contract with Quitline NC by 10%.
Increase the number of licensed providers in the service area(s) that are Certified Tobacco Treatment Specialists (CTTS).
Increase the awareness of secondhand smoke, environmental and tobacco policies through paid and earned media opportunities in the service area(s).
<b>C. Reporting/Monitoring Requirements</b>
Funded local health departments shall document and submit data on the following requirements:
The number of CTTSs trained in the county. At least 25% of the trained CTTSs should be external health care professionals from locations outside of the LHD. Summarize the engagement, maintenance, and collaboration with previously trained CTTS
Number of pregnant women who use any form of tobacco (inclusive of electronic nicotine devices such as e-cigs and vaping pens).
Number of 5A's trainings and number of staff and health care providers who participate. Specific data should be provided, including place of employment (LHD, FQHC, hospital, and other public/private health clinics, etc.).
Number of clients with documentation of primary, secondary, or tertiary tobacco/smoke exposure in their electronic medical records.
Number of public policies (including workplace policies) for smoke-free or tobacco-free workplaces and other indoor public places within the service area. Data should include qualitative information about workplaces, policies, and more.
Number of new businesses/work sites with a cessation program for employees and/or patrons.
Summary of paid and earned media opportunities in the service area, including samples of the paid and earned media.
Number of clients who received counseling and cessation services using the 5A's method and referrals made, in the electronic medical record.
If the LHD chooses to enter into an annual contract with the QuitlineNC for counseling and cessation services in the service area, a copy of the contract is to be sent to the DPH Program Manager within 60 days of that contract's execution.
<b>2. Ten Steps for Successful Breastfeeding, with a focus on Steps 3 &amp; 10</b>
Exclusive breastfeeding is considered one of the most effective preventative health measures to reduce child morbidity and mortality in the US and globally. <sup>11</sup> Infants who received any breastmilk were found to have a 60% lower risk of dying from Sudden Infant Death Syndrome (SIDS) and an overall lower risk of dying in their first year of life. <sup>(12,13,14)</sup> North Carolina (NC) has a lower rate of ever breastfeeding (75.3%) compared to the US (81.1%). <sup>14</sup> Breastfeeding at six and 12 months drops dramatically in both the US and in NC. In 2015, the rate of breastfeeding at six and 12 months was 47.5% and 30.0%, respectfully. <sup>14</sup> In the US, the rates were 51.8% and 30.7% in 2016. <sup>14</sup> Although breastfeeding rates have increased in the US and NC, racial/ethnic disparities exist. According to the National Immunization Survey (2016), non-Hispanic (NH) whites had higher rates of breastfeeding at initiation (86.6%), six months (61.5%), and 12 months (39.6%) compared to NH-African Americans who had the lowest rates: (initiation, 74.0%; six months, 48.6%; and 12 months,

27.1%). NH-Asians had the highest overall rates of breastfeeding at initiation (88.2%), six months (72.1%), and 12 months (51.6%).<sup>15</sup> Racial/ethnic disparities in NC mirror those of the US. At discharge, 87.6% of NH-white women reported initiating breastfeeding compared to 73.1% of NH-African Americans, 95.2% of non-Hispanic Other, 94.7% of Latina.<sup>16</sup>

The Ten Steps for Successful Breastfeeding is an evidence-based protocol used by Baby-Friendly USA to encourage and promote breastfeeding.<sup>17</sup> This evidence-based protocol is best implemented by hospitals; however, Steps 3 and 10 focuses on broader strategies to increase initiation, duration, and support of breastfeeding. Step 3 of the Ten Steps for Successful Breastfeeding states to “*Inform all pregnant women about the benefits of and management of breastfeeding.*” Step 10 of the Ten Steps for Successful Breastfeeding states to “*Foster the establishment of breastfeeding support groups and refer mothers to them on discharge from the hospital or birth center.*”

To address the racial/ethnic disparities in breastfeeding initiation and duration in North Carolina, this strategy will target minority-women and their social networks to increase support, access, knowledge, and resources. In NC, NH African American, NH-Native American/American Indian, and Hispanic women have the lowest rates of breastfeeding.

#### **A. Scope of Services**

Provide culturally and linguistically appropriate education to men and women of reproductive age to increase the initiation and continuation of breastfeeding. Educational opportunities may include community outreach events; educational workshops; distribution of educational materials; or preconception, prenatal, and postnatal counseling.

Provide education and training on breastfeeding guidelines as recommended by the American Academy of Pediatrics (AAP) to all clinical and non-clinical staff in the local health department and other public/private health care practices\* who interact with women of reproductive age or infants to recognize that breastfeeding is a normal physiologic process that has short- and long-term benefits for the mother-baby dyad.

Implement and enhance connections with community-based and faith-based organizations to promote the normalcy of breastfeeding within the social support systems (fathers, partners, grandmothers, church members, & neighbors) for women of reproductive age. This includes but is not limited to implementing or enhancing breastfeeding support groups, breastfeeding classes, breastfeeding rooms, or education for family and social networks.

Maintain a designated group to manage breastfeeding policy development and review LHD staff orientation, and education in the service area(s).

Strengthen partnerships between the local health department and Title V program providers, WIC, maternity care/perinatal care, quality improvement partners, state and local breastfeeding coalitions, and faith-based and community-based organizations. Partnerships should focus on increasing the access to peer support groups within the community.

Utilize social media, including radio, television, the internet, billboards, or newspaper, to increase the awareness of breastfeeding for the mom-baby dyad.

**Select one (1) of the following Scope of Services to implement in addition to the above listed activities:**

#### **Making it Work: Empowering Employers and Mothers:**

Utilize approved resources for the increasing the number of breastfeeding friendly businesses/work sites in the service area. LHDs should provide education, consultation, and information to the businesses/work sites.

Resources include the adapted Making It Work Toolkit

(<https://www.workwellnc.com/NCMakingItWork.php>) and the Businesses Leading the Way:

(<http://www.nutritionnc.com/breastfeeding/index.htm>)

**Breastfeeding Friendly City Program:**

Collaborate with communities in the service area(s) to increase the support for the breastfeeding family through the implementation of the Breastfeeding Friendly City program, which includes implementing some of the following strategies within designated communities:

1. Developing or enhancing a local breastfeeding coalition;
2. Developing community-based peer support groups, such as La Leche League or similar mother-to-mother groups;
3. Working with at least one community hospital to apply for the North Carolina Maternity Center Breastfeeding Designation or to pursue designation as a Baby Friendly Hospital;
4. One public establishment for every 1000 community citizens or 25 (whichever is less) participate in the “Breastfeeding Welcomed Here” program; and
5. One employer for every 5000 community residents or 10 (whichever is less) to receive the “Breastfeeding Employee Support Award” from the Making It Work initiative.

For more information, review:

[AMCHP Communities Supporting Breastfeeding](#)

[Carolina Global Breastfeeding Institute \(CGBI\): Breastfeeding Friendly Community Designation](#)

**Shared Decision-Making using Patient Decision Aids:**

Implement a shared decision-making process with the use of patient decision aids that will promote the best clinical evidence for breastfeeding. Patient decision aids must be integrated into the clinical workflow to assist with the patient’s “decision journey”. This strategy will allow patients to contemplate options, gather additional information, consult with family and friends, consider individual preferences, and address their personal concerns. The shared decision-making process will increase provider-patient engagement and allow health care providers and patients to make informed, explicit decisions together. Patient decision aids can be in the following formats: written, video, or web-based. Breastfeeding decision aids will include evidence-based information & practices; present information objectively; be written in appropriate reading and literacy level; and allow patients to clarify their preferences/values. LHDs selecting this strategy will incorporate breastfeeding-focused decision aids at specific prenatal care visits as well as targeted decision aids for the support systems of patients. After patient or family member reviews the decision aid, the provider will follow up with a targeted discussion to engage the patient in dialogue about the content just reviewed. Additional information about Patient Decision Aids can be found: <https://decisionaid.ohri.ca/implement.html> or [http://familiesusa.org/sites/default/files/product\\_documents/Shared-Decision-Making.pdf](http://familiesusa.org/sites/default/files/product_documents/Shared-Decision-Making.pdf)

**Implement Prenatal Breastfeeding Education:**

The LHD shall provide prenatal breastfeeding education that follows the Carolina Global Breastfeeding Institute’s (CGBI) Ready, Set, BABY curriculum (or similar curriculum that adheres to Baby-Friendly, USA’s requirements for prenatal breastfeeding education) for increasing pregnant families access to prenatal breastfeeding education. This may include the development of free prenatal breastfeeding classes offered on a consistent schedule and advertised to the community, partnering with external entities (breastfeeding support groups, medical providers, maternity care centers, and retailers) to develop or enhance prenatal breastfeeding support. CGBI’s Ready, Set, BABY curriculum can be found at: <https://sph.unc.edu/cgbi/resources-ready-set-baby/>.

**Establish Public Lactation Rooms:**

The LHD shall provide a lactation room for the public in accordance with the “Fairness For Breastfeeding Mothers Act of 2019”. The LHD should work with other “Covered Public Buildings” to establish the required



Lactation Room. Additional information about the requirements of the “Fairness For Breastfeeding Mothers Act of 2019” can be found at <a href="https://www.congress.gov/bill/116th-congress/senate-bill/528/text">https://www.congress.gov/bill/116th-congress/senate-bill/528/text</a> .
<b>B. Performance Measures</b>
Increase the percentage of infants who are breastfeeding at discharge from the hospital.
Increase the percentage of WIC-eligible infants who are breastfeeding at six and 12 months.
Increase the number of unduplicated men and women of reproductive age, and members of their social support who received education, support, and information to increase the initiation and continuation of breastfeeding.
Increase the number of staff and health care providers from the local health department and other public/private health care practices* that receive training to support the initiation and continuation of breastfeeding women.
Increase the number of collaborations with partner organizations, community-based and faith-based organizations that support breastfeeding women and their families.
Increase the presence of social media messages that provide information about the importance of breastfeeding.
<i>Select appropriate performance measure(s) to match the selected scope of service above:</i>
Increase the number of businesses/worksites that are breastfeeding-friendly for patrons and/or employees.
The number of organizations, businesses, hospitals, day care/childcare centers, etc. that are engaged in working towards the Breastfeeding Friendly City Program.
Increase the number of staff and health care providers from the LHD and other public/private health care practices* who are trained and implementing Patient Decision Aid practices.
Engage 100% of women during their prenatal care visit in one or more targeted decision aids followed by prompted discussion with provider about breastfeeding during their prenatal visit at the LHD and other public/private health care practices.
Increase the number of public lactation rooms in the service area.
<b>C. Reporting/Monitoring Requirements</b>
Funded local health departments shall document and submit data on the following requirements:
The number and type of breastfeeding education training that staff and health care providers in the local health department and at other public/private health care practices* participate.
The number of community-based and faith-based organizations that support breastfeeding women and their families with breastfeeding support groups, breastfeeding education classes, breastfeeding rooms, etc.
The number and type of partnerships that have developed in the service area with stakeholders and other programs.
<i>Select the appropriate reporting requirement(s) to match the selected scope of services</i>
The number of businesses/worksites that are engaged in becoming breastfeeding-friendly for patrons and/or employees.
Provide information on the initiation and progress of counties/ communities/etc. that begin the process to becoming a Breastfeeding Friendly City Program.
The number of staff and health care providers who are trained and implementing Patient Decision Aid method.
The number of women who have been engaged with one or more of the patient decision aids during their prenatal visit in the local health department and other public/private health care practices.
The number of public lactation rooms available in the service area.
*Other private/public health care providers or facilities include, but are not limited to federally qualified community health centers (FQHC), OB/GYN, family medicine, pediatric practice, rural/migrant health centers, etc.

## **PROGRAM AIM 3: Improved Health Status of Children Ages 0-5**

### **1. Positive Parenting Program (Triple P)**

The overarching goals of Triple P are:

- a. To promote the independence and health of families through the enhancement of parents' knowledge, skills, confidence, and self-sufficiency.
- b. To promote the development of non-violent, protective, and nurturing environments for children.
- c. To promote the development, growth, health, and social competence of young children; and
- d. To reduce the incidence of child maltreatment and behavioral/emotional problems in childhood and adolescence.
- e. To reduce out-of-home placements.
- f. To reduce emergency department visits related to abuse and neglect.
- g. To reduce out of childcare/school suspensions related to behavioral issues.

There are five levels of Triple P, from conducting a media-based parent information campaign, to providing brief group and individual sessions, to providing intensive individually tailored programs. The level of intervention is based upon the needs of the parents and family. A Triple P provider must receive training to become an accredited provider in each Triple P level of services. The five Triple P levels are:

1. Level One – conduct a media-based parent information campaign.
2. Level Two – provide specific advice to parents on solving common child developmental issues and minor behavioral problems.
3. Level Three – provide brief programs (60 minutes over four sessions) combining advice with rehearsal and self-evaluation as required to teach parents to manage discrete child problem behaviors.
4. Level Four – provide a broad-focus program (about 10 hours over 8 to 10 sessions) for parents requiring intensive training in positive parenting skills, generalization enhancement strategies and application of parenting skills to a range of target behaviors.
5. Level Five – provide intensive individually tailored programs (up to 11 sessions) for families with child behavior problems and family dysfunction. Program modules include practice sessions, mood management strategies, stress coping skills, partner support skills, attribution retraining and anger management.

### **A. Scope of Services**

1. Adhere to the standards set by Triple P America, as described in the Triple P Implementation Manual, to ensure that the project is implemented with model fidelity.
2. Hire and maintain a 1.0 FTE local Triple P Implementation Specialist (Coordinator) to oversee the expansion of Triple P under this Agreement Addendum. This person will participate in quarterly North Carolina Triple P State Learning Collaboratives, work collaboratively with the Division of Child and Family Well-Being's (DCFW) Triple P Program Manager, and participate on other local community advisory boards to assure integration of Triple P into the system of care as applicable.
3. Develop by August 31, 2024, an implementation plan for the service area and submit it to the DCFW Triple P Program Manager for review and approval using the template provided by Triple P America with guidance from the DCFW Triple P Program Manager and Triple P America. The implementation plan is to include:
4. Create a training schedule for practitioners to access the various levels of Triple P to be implemented in the service area.
5. Develop a plan for peer-to-peer coaching sessions for trained practitioners;

6. Create a plan for data collection across the service area;
7. Formulate a community outreach plan that includes media strategies for both caregivers (families) and practitioners (those providing services to families);
8. Develop an annualized budget;
9. Create a practitioner/child-serving agency support plan, including the use of parent support materials, refresher and attrition training, Peer Assisted Supervision and Support (PASS), Triple P integration into the child-serving agency, and practitioner service delivery plan;
10. Develop job descriptions and work plans for key staff; and
11. Note-only one implementation plan for both Title V and ICO4MCH Triple P activities needed.
12. Maintain membership and participation in the service area - Triple P Implementation Team that includes representatives from the other partner counties in the service region. The Triple P Implementation Team will meet quarterly and will advocate for the implementation or continuation of Triple P in the county or counties and support strategies for sustainability. They will also develop, maintain, and update, as needed, Memoranda of Agreements (MOAs) with local child serving agencies and practitioners to engage them in participation in Triple P provider training courses (inclusive of pre-accreditation, accreditation, and workshops), delivery of Triple P, and support (peer coaching and data reporting) for the local Triple P efforts.
13. Develop, maintain, and update as needed a Memoranda of Agreement (MOA) with local agencies participating in the coordinating council that support the local Triple P efforts. Develop and maintain an agreement with Triple P America for ongoing technical assistance and support.
14. Participate in the North Carolina Triple P State Learning Collaborative (Collaborative). The Collaborative will share best practices, provide peer support, monitor data collection, and develop quality improvement strategies, share social marketing strategies, establish a network of open enrollment trainings, and participate in professional development opportunities. Coordinate with the Triple P Online State Coordinator to provide local support for families in the service area(s) who are accessing Triple P via the online modules.

#### B. Performance Measures

1. Increase the number of families/caregivers with children ages 0–5 served.
2. Increase the number of children ages 0–5 served.
3. Increase satisfaction among families/caregivers with children ages 0–5 within the pre-test and post-test intervention surveys.
4. Increase the number of Triple P Online users who have children ages 0–5.
5. Increase the number of practitioners (child serving agencies and other practitioners) where children ages 0–5 are served who receive accreditation by Triple P America, including child care centers, day care centers, home visiting programs, pediatric and family practice clinics, faith-based facilities, etc.
6. Decrease the number of childcare suspension or expulsions due to behavioral issues for children ages 0–5 served.
7. Increase outreach and educational activities among parents/caregivers of children, ages 0 – 5, for the Triple P Online program and Triple P programs.

#### C. Reporting/Monitoring Requirements

Funded local health departments shall document and submit data on the following requirements:

1. The number of children, 0–5 served.
2. The number of practitioners who provide services for families with children ages 0 – 5, who are trained and accredited.



3. The number of outreach and educational events for Triple P online programming and Triple P in the service area(s) for parents/caregivers.
2. Local Health Departments that are interested in selecting Triple P (Positive Parenting Program) as one of its evidence-based programs must contact Triple P America before responding to this RFA. The contact for Triple P America is Ashley Lindsay, Implementation Consultant, Triple P America at 803.661.4711.

### **Family Connects Newborn Home Visiting Program**

The overarching goal of the Family Connects Newborn Home Visiting program is to reduce emergency medical care costs through improvement in parenting and infant well-being. All parents of newborns 2–12 weeks old born in the service area are eligible for this service. Family Connects Newborn Home Visiting provides the following services:

- a. One home visit by a registered nurse to all parents of newborns living in service area and
- b. Two additional home visits are available from the nurse home visitor for families who need additional support.
- c. The grantee will sub-contract with the Center for Child and Family Health (CCFH) for technical assistance, data management, and model implementation.

### **Scope of Services**

1. Hire and maintain a home visiting staff composed of 1.0 FTE Nurse Home Visitor for every 200 births in the service area (total FTE will depend on the total number of births in the service area).
2. For each active family, utilize the required service delivery and assessment forms collected and stored in the CCFH database.
3. Contact the families of at least 70% of all resident births within the service area by telephone.
4. Conduct an initial home visit with the families of at least 75% of the resident births who received an initial phone call inquiry.
5. Utilizing the Family Support Matrix, nurses will maintain an inter-rater agreement of at least 75%. The nurse home visitor rating for each factor reflects the level of family needs and risk of future problems. The Family Support Matrix includes four domains known to predict parent and child well-being and to prevent child maltreatment. These include four domains (health care, caring for an infant, safe home and parent support) with three questions in each domain (a total of 12 factors). The following scores indicate the level of risk and subsequent action:
  - a. A score of 1 is identified as “no or low risk” and receives no subsequent intervention;
  - b. A score of 2 is identified as “mild to moderate risk” and receives short-term nurse-delivered intervention on a topic over 1 -3 sessions;
  - c. A score of 3 is identified as “high risk” and receives a connection or referral to a community resource tailored to address the specific family need; and
  - d. A score of 4 is identified as “immediate danger” and receives immediate emergency intervention.
- e. The inter-rater agreement metric is the cumulative rate of agreement between nurse home visitors and the nursing supervisor in rating the family risk during the Quality Assurance checks conducted quarterly by the nursing supervisor.
6. Maintain nurse fidelity to the home visit model protocol of at least 75%. The metric is a cumulative rate of overall nurse home visitor adherence to the manualized protocol as measured by the Quality Assurance checks conducted quarterly by the nurse supervisor. The nurse fidelity checklist contains 62 individual model components which are covered in each integrated home visit. The components cover the following domains:
  - a. Introduction by the nurse (a total of 4 components);

- b. Support for health care with supportive guidance (a total of 17 components);
- c. Support for caring for the infant with supportive guidance (a total of 8 components);
- d. Support for a safe home with supportive guidance (a total of 15 components);
- e. Support for parents with supportive guidance (a total of 8 components);
- f. Written screeners (a total of 2 components); and

**Planning** (a total of 8 components).

- vii. Deliver all program services based on the Family Connects Implementation and Policies Manual.

**B. Performance Measures**

- 1. Complete home visits in the service area with 60–70% of all births in the service area.
- 2. Complete an integrated home visit (IHV) with at least 75% of all families who agreed to participate in the program.
- 3. Complete successful home visits with families who require one or more visits after the completion of the initial integrated home visit with at least 75% of all families.
- 4. Complete successful follow-up phone calls with families who require one or more substantive phone calls after completion of the initial integrated home visit.
- 5. Complete successful referral linkages with parents who received one or more referrals for long term support.
- 6. Have observed fidelity to the home visitor model protocol in at least 75% of home visits.
- 7. Have nurse inter-rater reliability agreement with the Family Status Index in at least 75% of home visits.
- 8. Participate in weekly case conference meetings at the Center for Child and Family Health.
- 9. Complete documentation of family demographics on all families participating in the program.

**C. Reporting Requirements**

The following reporting/monitoring requirements may be tracked by the grantee and/or the grantor. Data shall be submitted from the monthly-quarterly reports provided by the purveyor, when available.

- 1. Number of infants born in the service area to residents.
- 2. The number of home visits scheduled.
- 3. The number of in-home visits completed.
- 4. The number of families receiving one or more follow-up in-home visits or telephone calls after completion of initial integrated home visit (IHV).
- 5. The number of families receiving one or more referrals for long-term support.
- 6. The number of referrals resulting in successful connections with community agency/resource.
- 7. The percentage of nurse fidelity to the home visit model protocol.
- 8. The percentage of nurse inter-rater agreement the rating family risk using the Family Support Matrix.
- 9. Documentation and summary of case review meetings as required by Center for Child and Family Health (CCFH) and the Local Health Department.
- 10. Family demographics which include maternal and child characteristics collected on all families participating in the program.

Local Health Departments that are interested in selecting the Family Connects program as one of its evidence-based programs must contact the Center for Child and Family Health (CCFH) in Durham, North Carolina before responding to this RFA. The contact at the CCFH is at 919-491-9883.

## **Appendix B: Online County-Level Data Sources**

### **A. STATE CENTER FOR HEALTH STATISTICS (SCHS) WEBSITE**

1. [Basic Automated Birth Yearbook \(BABYBOOK\)](#)

This annual report contains tables showing statewide and county counts for resident live births classified by selected infant and maternal characteristics.

2. [BRFSS Survey Results](#) (not county specific, but state and regional data available)

3. [Child Deaths in NC](#) (grouped by cause and also by age group)

4. [County Health Data Book](#)

This website has links to county data related to the topics of Pregnancy and Live Births, Life Expectancy, Mortality, and Morbidity. The most recent book is displayed; to find book for other years, scroll to bottom of page and select a specific year. Perhaps one of the most helpful data tables on this website is the *Birth Indicators Tables by State and County* which is found as the last bullet under the Pregnancy and Live Births section. Use the dropdown menu to select the county of interest to find information by racial/ethnic population group about births and birth outcomes (gestational age; birthweight; prenatal care; etc.).

5. [Detailed Mortality Statistics](#)

6. [Infant Mortality Statistics](#)

7. [NC Reported Pregnancies](#)

8. [NC Vital Statistics, Volume 1: Population, Births, Deaths, Marriages, Divorces](#)

9. [NC Vital Statistics, Volume 2: Leading Causes of Death](#)

10. [Life Expectancy - State & County Estimates](#)

### **B. DATA AVAILABLE ON NC CHILD WEBSITE/KIDS COUNT NC**

1. [NC Child County Data](#)

This website provides "the latest data for key indicators in five areas of children's well-being: A Strong Start, Family Economic Security, Nurturing Homes and Communities, Health and Wellness, and High-Quality Education" for all counties in NC. Links to the County Data Dashboard, downloadable county data cards, the most recent NC Child Health Report Card, the KIDS COUNT Data Center, and the KIDS COUNT Data book are all found on this webpage.

## **Appendix C: Health Equity Training Resources**

**Compiled by the Women, Infant, and Community Wellness Section**

### **Racial Equity:**

- **American Public Health Association (APHA): Advancing Racial Equity Webinar Series and Discussion Guide**
  - o <https://apha.org/Events-and-Meetings/Webinars/Racial-Equity>
- **National Association of County and City Health Officials: Roots of Health Inequity (NACCHO): Roots of Health Inequity**
  - o <http://rootsofhealthinequity.org/>
- **Reproductive Health National Training Center (RHNTC): Structures & Self: Advancing Equity and Justice**
  - o <https://rhntc.org/resources/structures-self-advancing-equity-and-justice-elearning>
- **Robert Wood Johnson Foundation: Moving from Talk to Action: Advancing Equity with Results Based Accountability**
  - o <https://www.alignforhealth.org/resource/moving-from-talk-to-action-advancing-equity-with-results-based-accountability/>

### **Reproductive Justice:**

- **APHA: A Path to Reproductive Justice: Research, Practice and Policies**
  - o <https://apha.org/Events-and-Meetings/APHA-Calendar/Webinar-Events/2020/Racial-Equity-Part-2>
- **Region V Public Health Training: Reproductive Justice 101**
  - o <https://www.mittrainingcenter.org/courses/rj101a0719noce>

### **Community Engagement:**

- **Association of Maternal & Child Health Programs (AMCHP): Shifting Power in Practice: Strategies for Centering People with Lived Experience When Making Evidence-Based Decisions**
  - o <https://amchp.org/courses/shifting-power-in-practice/>

### **Cultural Competency:**

- **RHNTC: Cultural Competency in Family Planning Care**
  - o <https://rhntc.org/resources/cultural-competency-family-planning-care-elearning>
- **US Department of Health and Human Services, Office of Minority Health (OMH): Culturally and Linguistically Appropriate Services (CLAS) in Maternal Health Care**
  - o <https://thinkculturalhealth.hhs.gov/maternal-health-care/>

### **Policy:**

- **Maternal Health Learning & Innovation Center: Centering Equity in Maternal Health Innovation through Policy and Engagement**
  - o <https://maternalhealthlearning.org/resources/mhlic-module-centering-equity-in-maternal-health-innovation-through-policy-and-engagement/>
- **#impactEQUITYNC: North Carolina Health Equity Impact Assessment**
  - o <https://ncchild.org/health-equity-impact-assessment/>

### **Sexual and Gender Minority Health Inequities:**

- **National LGBTQIA+ Health Education Center: Sexual and Gender Minority Health Inequities**
  - o <https://www.lgbtqiahealtheducation.org/courses/sexual-and-gender-minority-health->

[inequities/](#)

- **RHNTC: The Need for Accepting and Affirming Care in Title X Settings**
  - o <https://rhntc.org/resources/need-accepting-and-affirming-care-title-x-settings-video-series>
- **RHNTC: Gender Appropriate Language: Practical Skill Development Webinar**
  - o <https://rhntc.org/resources/gender-appropriate-language-practical-skill-development-webinar>

Social Determinants of Health:

- **Region V Public Health Training Center: Determinants of Health**
  - o <https://www.mittrainingcenter.org/courses/dohes0720noce>
- **RHNTC: Addressing Social Determinants of Health in Family Planning Care**
  - o <https://rhntc.org/resources/addressing-social-determinants-health-family-planning-care-meeting-package>
- **Public Health Foundation: What Are Social Determinants of Health?**
  - o <https://www.train.org/main/search?query=social%20determinants%20of%20health&type=course>

Trauma-Informed Care:

- **Reproductive Health Branch, WICWS: Trauma-Informed Reproductive Health Care – Practical Pearls and Pitfalls**
  - o [https://www.zoomgov.com/rec/play/8NfSABs8\\_Br7GH3ulKlrIUy3wopbicNUECP8qmQmZW\\_euSWFMzn5SCcJPw1ZvT-DCbF3xblylFCgIOWd.JNm4lItpnD8upTtc?continueMode=true](https://www.zoomgov.com/rec/play/8NfSABs8_Br7GH3ulKlrIUy3wopbicNUECP8qmQmZW_euSWFMzn5SCcJPw1ZvT-DCbF3xblylFCgIOWd.JNm4lItpnD8upTtc?continueMode=true)
- **RHNTC: Understanding Trauma and the Six Core Principles of a Trauma-Informed Approach**
  - o <https://rhntc.org/resources/understanding-trauma-six-core-principles-trauma-informed-approach-video>
- **RHNTC: Trauma-Informed, Resilience-Oriented, and Equitable Care: Helping Staff and Clients Feel Safe**
  - o <https://rhntc.org/resources/trauma-informed-resilience-oriented-equitable-tiroe-care-helping-staff-clients-feel-safe>

## **Appendix D: Health Equity Impact Assessment Tool**

[Health inequities](#) are complex and typically longstanding problems that affect our communities. These unjust outcomes are further impacted by policies and programs created with the intention of improving quality of life. By acknowledging the factors that contribute to [health disparities](#) and health inequities, we can be inclusive and systematic in our approach to address the inequities that negatively impact the health of certain populations. **The [Health Equity Impact Assessment](#) (HEIA) encourages focus on a particular policy/program and its impact on health disparities and health inequities.** The tool allows a team to think outside the box and consider all factors that could potentially impact the health of populations at risk. The HEIA helps facilitate conversations about factors that support or weaken health, including the [root causes](#) of disparities and inequities. Information gathered throughout this process will provide community perspective and guide your team in strategic planning to modify an existing or proposed policy/program. The HEIA will help to develop concrete methods and action steps aimed at improving policies/programs in the hope of reducing health disparities and inequities within the impacted population(s). In addition, the HEIA will:

- **Analyze Data** to determine potential impact of policies/programs.
- **Involve Stakeholders and Impacted Populations.** Effective health equity assessments require early and continued involvement of members of impacted populations. It is important to have knowledge of the community (resources, contacts, and partners) and to gain their perspective on current policies and programs as well as understand the potential impacts on the community, both positive and negative.
- **Identify** ways to modify current or proposed policies or programs to ensure they reduce health disparities and inequities; **NOT** make them worse.
- **Provide information** on uneven impacts on various populations or communities.
- **Recommend** modifications to policies or programs that promote equity and ease negative impacts.

The HEIA consists of three Pre-Work steps, team-building activities, four implementation steps, a glossary, and worksheets. To access a full copy of the HEIA, visit <https://ncchild.org/health-equity-impact-assessment> provides an overview of the HEIA tool and an option to download.

## **Appendix E: Outline of data provided by DPH to the funded LHD**

The table below indicates additional data elements that will be provided to the funded Local Health Department (LHD) by DPH. Data will be provided on a quarterly, bi-annual, or annual basis, depending on the evidence-based strategy (EBS). Data not listed will be provided by the funded LHD. This rubric is subject to change.

<b>Evidence-based strategy</b>	<b>Data element</b>	<b>Procedure</b>
Using a Reproductive Justice Framework to improve the utilization of Reproductive Life Planning (RLP).	-Unique monthly users of long-acting reversible contraception (LARC) services in the LHDs	-DPH will provide the LHD-HSA data quarterly to the LHDs.
Preconception Health	-QuitlineNC data (includes all demographic and county specific data on registered callers)	-DPH will provide data quarterly to the LHDs
Tobacco Cessation and Prevention	-QuitlineNC data (includes all demographic and county specific data on registered callers)  -Pregnant women who smoke/ use tobacco	-DPH will provide data quarterly to the LHDs  -NC State Birth Certificate data, annually.
Ten Steps for Successful Breastfeeding	-Breastfeeding initiation rates  -Breastfeeding duration at 6 and 12 months	-NC State Birth Certificate data, annually.  -Nutrition Services Branch, Crossroad's data system, annually
Positive Parenting Program (Triple P)	-Triple P online data	-DPH will provide data quarterly to the LHDs
Collective Impact	-Focus group/key informant interview data.	-Evaluators, contracted with DPH, will provide site specific summaries to DPH and each LHD.

## **Appendix F: Citations**

1. North Carolina State Center for Health Statistics
2. Small Area Health Insurance Estimates
3. U.S. Census Small Area Income and Poverty Estimates (SAIPE) Data and Mapping Tool. 2021 Available:  
[https://www.google.com/search?q=U.S+Census+Small+Area+Income+and+Poverty+Estimates+Data+and+Mapping+2021&rlz=1C1GCEU\\_enUS885US886&oq=U.S+Census+Small+Area+Income+and+Poverty+Estimates+Data+and+Mapping+2021&gs\\_lcrp=EgZjaHJvbWUyBggAEEUYOdIBCTY2MTk5ajBqN6gCALACAA&sourceid=chrome&ie=UTF-8](https://www.google.com/search?q=U.S+Census+Small+Area+Income+and+Poverty+Estimates+Data+and+Mapping+2021&rlz=1C1GCEU_enUS885US886&oq=U.S+Census+Small+Area+Income+and+Poverty+Estimates+Data+and+Mapping+2021&gs_lcrp=EgZjaHJvbWUyBggAEEUYOdIBCTY2MTk5ajBqN6gCALACAA&sourceid=chrome&ie=UTF-8)
4. U.S. Census American Community Survey
5. Moos MK, Dunlop AL, Jack BW, Nelson L, Conrod DV, Long R, et al. Healthier women, healthier reproductive outcomes: recommendations for the routine care of all women of reproductive age. *Am J Obstet Gynecol*. 2008;199: S280–S9
6. Centers for Disease Control and Prevention. DC. Recommendations to improve preconception health and health care – United States: a report of the CDC/ATSDR Preconception Care Work Group and the Select Panel on Preconception Care. *MMWR*. 2006; 55(No. RR-6).
7. Secura GM, Allsworth JE, Madden T, Mullersman JL, Peipert JF. The Contraceptive CHOICE Project: reducing barriers to long-acting reversible contraception. *Obstet Gynecolo*. 2010; 203:115e-7.
8. Gavin L, Moskosky MS, Carter M, Curtis K, Glass E, Godfrey E, et al. Providing Quality Family Planning Services. Recommendations of the CDC and U.S. Office of Population Affairs. *MMWR*. April 25, 2014; Vol. 63(4).
9. Winner B, Peipert J, Zhao Q, et al. Effectiveness of long-acting reversible contraception. *N Engl J Med*. 2012; 366:1998-2007.
10. Oregon Foundation for Reproductive Health One Key Question®
11. Jones G, Steketee RW, Black RE, Bhutta Za, Morriss SS, Bellagio Child Survival Study Group: How many child deaths can we prevent this year? *Lancet*. 2003, 362(9377):65-71.
12. Ip S, Chung M, Raman G, Trikalinos TA, Lau J. A summary of the Agency for Healthcare Research and Quality’s evidence report on breastfeeding in developed countries. *Breastfeed Med*. Oct 2009;4 Suppl 1:S17- 30. doi:10.1089/bfm.2009.0050 5.
13. Victora CG, Bahl R, Barros AJ, et al. Breastfeeding in the 21st century: epidemiology, mechanisms, and lifelong effect. *Lancet*. Jan 30, 2016;387(10017):475-90. doi:10.1016/ s0140-6736(15)01024-7.
14. Eidelman AI, Schanler RJ. Breastfeeding and the use of human milk: an analysis of the American Academy of Pediatrics 2012 Breastfeeding Policy Statement. *Breastfeed Med*. Oct 2012;7(5):323-4. doi:10.1089/ bfm.2012.0067.



15. CDC Breastfeeding Rates: [https://www.cdc.gov/breastfeeding/data/nis\\_data/results.html](https://www.cdc.gov/breastfeeding/data/nis_data/results.html)
16. Office of Disease Prevention and Health Promotion. (n.d.). Increase the proportion of infants who are breastfed exclusively through age 6 months. Healthy People 2030. U.S. Department of Health and Human Services. <https://health.gov/healthypeople/objectives-and-data/browse-objectives/infants/increase-proportion-infants-who-are-breastfed-exclusively-through-age-6-months-mich-15>
17. US Department of Agriculture; US Department of Health and Human Services. Dietary guidelines for Americans, 2020–2025. 9th ed. Washington, DC: US Department of Agriculture, US Department of Health and Human Services; 2020.
18. Li R, Perrine CG, Anstey EH, Chen J, MacGowan CA, Elam-Evans LD. Breastfeeding trends by race/ethnicity among US children born from 2009 to 2015. *JAMA Pediatrics* 2019;173:e193319. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6802058/>
19. Bartick MC, Jegier BJ, Green BD, Schwarz EB, Reinhold AG, Stuebe AM. Disparities in breastfeeding: impact on maternal and child health outcomes and costs. *J Pediatr* 2017;181:49–55.e6. <https://pubmed.ncbi.nlm.nih.gov/27837954/>
20. North Carolina State Center for Health Statistics. October 10, 2019. Prevalence of Breastfeeding Initiation. 2018 North Carolina Pregnancy Risk Assessment Monitoring System Survey Results. North Carolina State Center for Health Statistics. [https://schs.dph.ncdhhs.gov/data/prams/2018/BF\\_INIT.html](https://schs.dph.ncdhhs.gov/data/prams/2018/BF_INIT.html)
21. North Carolina State Center for Health Statistics. October 10, 2019. Breastfeeding at 8 weeks after delivery. 2018 North Carolina Pregnancy Risk Assessment Monitoring System Survey Results. North Carolina State Center for Health Statistics. <https://schs.dph.ncdhhs.gov/data/prams/2018/BF8weeks.html>
22. Wouk K, Tully KP, Lobbok MH. Systematic Review of Evidence for Baby-Friendly Initiative Step 3: Prenatal Breastfeeding Education. *Journal of Human Lactation*. 2017; Vol 33(10): 50-82
23. North Carolina Pregnancy Risk Assessment Monitoring System Survey Results. Available: [https://schs.dph.ncdhhs.gov/data/prams/2017/BF\\_INIT.html](https://schs.dph.ncdhhs.gov/data/prams/2017/BF_INIT.html)
24. North Carolina State Center for Health Statistics. Available : <https://schs.dph.ncdhhs.gov/data/vital/ims/2019/matchar2019.html>

## **Appendix G: Doula Services Satisfaction Survey**

Participant: \_\_\_\_\_  
 Baby's Date of Birth: \_\_\_\_\_

Date: \_\_\_\_\_

1. In partnership with your doula, did you prepare a birth plan/wish list to share with your doctor or midwife and nurse?	<input type="checkbox"/> YES <input type="checkbox"/> NO
2. Did you feel that you were involved in the decision-making process and felt listened to during your labor and birth - a. By your doctor/midwife? b. By your nurse?	<input type="checkbox"/> NEVER <input type="checkbox"/> SOMETIMES <input type="checkbox"/> ALWAYS <input type="checkbox"/> NEVER <input type="checkbox"/> SOMETIMES <input type="checkbox"/> ALWAYS
3. What comfort measures and coping techniques did you find to be the <b>most helpful</b> while you labored at home and in the hospital? ( <i>Check all that apply</i> )	<input type="checkbox"/> Birth ball <input type="checkbox"/> <i>Breathing techniques</i> <input type="checkbox"/> <i>Massage</i> <input type="checkbox"/> <i>Music</i> <input type="checkbox"/> <i>Position changes</i> <input type="checkbox"/> <i>Shower</i> <input type="checkbox"/> <i>Tub</i> <input type="checkbox"/> <i>Walking</i> <input type="checkbox"/> <i>Other (please specify)</i> _____
4. What comfort measures or coping techniques were <b>not helpful</b> to you in labor? ( <i>Check all that apply</i> )	<input type="checkbox"/> Birth ball <input type="checkbox"/> <i>Breathing techniques</i> <input type="checkbox"/> <i>Massage</i> <input type="checkbox"/> <i>Music</i> <input type="checkbox"/> <i>Position changes</i> <input type="checkbox"/> <i>Shower</i> <input type="checkbox"/> <i>Tub</i> <input type="checkbox"/> <i>Walking</i> <input type="checkbox"/> <i>Other (please specify)</i> _____
5. a. Did you use any of these pain medications during your labor? b. Did the medication work as you expected?	<input type="checkbox"/> Epidural <input type="checkbox"/> Nitrous oxide <input type="checkbox"/> IV medication <input type="checkbox"/> None <input type="checkbox"/> YES <input type="checkbox"/> NO
6. Please describe what happened after your baby was born. a. Did you hold your baby directly on your chest (skin-to-skin) for at least 1 hour immediately after birth? b. Did you start nursing your baby within the first hour?	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> If no, please explain _____ <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> If no, please explain _____
8. What did you feed your baby while in the hospital?	<input type="checkbox"/> Only their breastmilk <input type="checkbox"/> A mix of their breastmilk and formula <input type="checkbox"/> Only formula <input type="checkbox"/> <i>Other (please specify)</i> _____
9. What are you currently feeding your baby?	<input type="checkbox"/> Only their breastmilk <input type="checkbox"/> A mix of their breastmilk and formula <input type="checkbox"/> Only formula <input type="checkbox"/> <i>Other (please specify)</i> _____
10. If you are feeding your baby breastmilk, what has been the most helpful to get you started and/or to continue breastfeeding? ( <i>Check all that apply</i> )	<input type="checkbox"/> In-hospital support (nurse/lactation consultant) <input type="checkbox"/> Professional support (lactation consultant/counselor) <input type="checkbox"/> Local Health Department support (WIC Breastfeeding Peer Counselor) <input type="checkbox"/> Community support (support groups) <input type="checkbox"/> Family/Friends <input type="checkbox"/> <i>Other (please specify)</i> _____
11. Please describe your birth experience in 2-3 descriptive words.	
12. Describe how your doula contributed to your birth experience in 1-2 ways.	_____ _____ _____
13. Would you recommend that other women use a doula during their birth?	<input type="checkbox"/> YES Please tell us why? _____ <input type="checkbox"/> NO Please tell us why? _____ <input type="checkbox"/> OTHER Please specify _____

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